

San Radiology & Nuclear Medicine

Specialist Breast Imaging Request

or Interventional Procedure Referral

Patient Name: _____

D.O.B: _____

Address: _____

Postcode: _____

Phone: _____

Mobile: _____

MRN: _____

BREAST IMAGING EXAMINATIONS (Please select region first then examination and/or procedure)

- Bilateral Right Left
(Axillae & chest wall routinely included)

MAMMOGRAPHY AND ULTRASOUND:

- 2D/3D Mammography* + Breast Ultrasound
 2D/3D Mammogram*
 Breast Ultrasound
 Contrast Enhanced** Mammography (CEM)
 Contrast Enhanced** Mammography (CEM) + 3D Mammography

* Includes Breast Density Assessment
 ** Contrast Non Claimable

BREAST MRI:

- Standard Protocol
 Medicare Eligible
 Insert MBS Item: _____
 Refer to the back of this form for MBS item numbers, criteria and indications)
 Non-Medicare Eligible
 RAPID Sequence Protocol (Non-Medicare Eligible)
 +/- Second Look Ultrasound
 +/- Biopsy (US Guided)

BREAST INTERVENTIONAL PROCEDURES*:

- Ultrasound-guided Biopsy (FNA, Core, Vacuum Assisted)
 Mammographic-guided Vacuum Assisted Biopsy
 MRI-guided Biopsy

*Please accept this form as a referral for this patient for investigation, opinion, treatment and/or management of a condition or problem.

BREAST SURGERY PLANNING PROCEDURES*:

- Mammography guided
 Ultrasound guided
 Placement of Lesion Marker (+/- Post Procedural Mammo)
 Localisation (+/- Post Procedural Mammo)
 Hookwire Other
 Breast Lymphoscintigraphy (with SPECT/CT)

FDG PET-CT (Refer to the back of this form for criteria and indications):

- FDG for Staging (MBS Item 61524) → with Diagnostic CT – as per protocol or specify region:
 FDG for Staging / Restaging (MBS Item 61525)

SYDNEY ADVENTIST HOSPITAL
 185 Fox Valley Rd, Wahroonga NSW 2076
Radiology Level 3, Tulloch Building
Nuclear Medicine Level 3, San Clinic Suite 306
PET-CT Level 2, Tulloch Building Suite 216

Make an appointment



OTHER IMAGING EXAMINATIONS:

- NM Tc-99m Whole Body Bone Scan (+/- SPECT-CT)
 Staging CT: _____
 Other: _____

PRECAUTIONS:

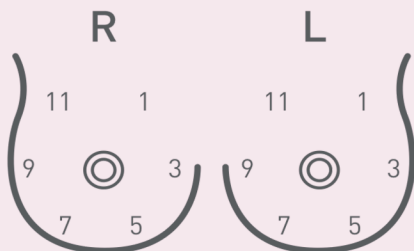
- Pregnant? Yes No
 Anticoagulants _____
 Allergies _____
 eGFR# _____
 for contrast only if >60 years or known renal impairment

CLINICAL INFORMATION

Please include relevant clinical details and indicate on the breast image provided, (O) lump, (///) pain, (+++++) scar, (|||||) thickening. Please provide pathology report where applicable.

REASON FOR ASSESSMENT

- Surveillance (family history, previous breast Ca)
 Thick/lumpy breast tissue
 Breast and/or axilla lump(s)
 Nipple change
 Skin change
 Risk Assessment
 Breast Pain



Date for follow-up consultation: _____

REFERRER DETAILS

Name: _____

Provider No: _____

Address: _____

Copy to: _____

Phone: _____ Fax: _____

Signature: _____

Date: _____

Your doctor has recommended you use San Radiology and Nuclear Medicine. You may choose another provider but please discuss this with your doctor first.

BREAST MRI / PET CT – MEDICARE ELIGIBLE INDICATIONS & CRITERIA (AS AT MARCH 2024)

MBS ITEM	INDICATIONS
<input type="checkbox"/> 63464 [Restricted to once in a 12 month period]	Specialist or Consultant Physician request which must identify the patient as being: 1. a patient who is asymptomatic and is younger than 60 years of age; and 2. at high risk of developing breast cancer due to one or more of the following: (a) genetic testing has identified the presence of a high risk breast cancer gene mutation in the patient or in a first degree relative of the patient; (b) both: (i) one of the patient's first or second degree* relatives was diagnosed with breast cancer at age 45 years or younger; and (ii) another first or second degree* relative on the same side of the patient's family was diagnosed with bone or soft tissue sarcoma at age 45 years or younger; (c) the patient has a personal history of breast cancer before the age of 50 years; (d) the patient has a personal history of mantle radiation therapy; (e) the patient has a lifetime risk estimation greater than 30% or a 10 year absolute risk estimation greater than 5% using a clinically relevant risk evaluation algorithm
<input type="checkbox"/> 63467	Specialist or Consultant Physician request where an abnormality was detected as a result of a screening MRI (item 63464) performed in the previous 12 months
<input type="checkbox"/> 63547	Specialist, Consultant Physician or GP request for an MRI scan of both breasts for the detection of cancer, if the request for the scan identifies that: (i) the patient has a breast implant in situ; and (ii) anaplastic large cell lymphoma has been diagnosed
<input type="checkbox"/> 63487	Specialist or Consultant Physician request that identifies: (i) the patient has been diagnosed with metastatic cancer restricted to the regional lymph nodes; and (ii) clinical examination and conventional imaging have failed to identify the primary cancer.
<input type="checkbox"/> 63489	MRI scan of one breast, performed in conjunction with a biopsy procedure on that breast and an ultrasound scan of that breast, if: a. the request for the scan identifies that the patient has a suspicious lesion seen on MRI but not on conventional imaging; and b. the ultrasound scan is performed immediately before the MRI scan and confirms that the lesion is not amenable to biopsy guided by conventional imaging.
<input type="checkbox"/> 63531	MRI of both breasts where the patient has a breast lesion, the results of conventional imaging examination are inconclusive for the presence of breast cancer, and biopsy has not been possible.
<input type="checkbox"/> 63533	MRI of both breasts where the patient has been diagnosed with breast cancer and there is a discrepancy between clinical assessment and conventional imaging assessment of the extent of the malignancy, and the results of breast MRI may alter treatment planning.
<input type="checkbox"/> 61524	Whole body FDG PET study where the patient is referred by a specialist or consultant physician, performed for the staging of locally advanced (Stage III) breast cancer in a patient considered suitable for active therapy.
<input type="checkbox"/> 61525	Whole body FDG PET study, where the patient is referred by a specialist or consultant physician, performed for the evaluation of suspected metastatic or suspected locally or regionally recurrent breast carcinoma in a patient considered suitable for active therapy.

*Medicare Definitions:

First degree relatives include: Mother, Father, Brother, Sister, Daughter, Son

Second degree relatives include: Aunt, Uncle, Nephew, Niece, Grandparents, Half Sibling

MY APPOINTMENT DETAILS

Appt Date: _____ / _____ / _____

Appt Time: _____

Note: _____

PATIENT INFORMATION

- For a quicker check in, please scan the QR code to send this request ahead of your appointment.
- Please bring this request and any relevant previous imaging with other providers to your appointment.

HOW TO FIND US

San Radiology | PET-CT:

Enter the Hospital entrance at the traffic lights on Fox Valley Road (Entry 1). Park in **P₁**

Nuclear Medicine: Enter the Hospital entrance at the traffic lights on Fox Valley Road (Entry 1). Park in **P₂**



www.sanradiology.com.au

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