SOUTH ATLANTA RADIOLOGY ASSOCIATES
UPPER RIVERDALE ROAD RIVERDALE, GA 30274
PHONE: (770)991-1010 FAX: (770) 997-8242
GRIFFIN LOCATION:
680 SOUTH 9TH STREET GRIFFIN, GA 30223
PHONE:(770)-228-7625 FAX: (770) 228-6843

PT ID#: ______________________

US RAM#: ______________________

(PLEASE COMPLETE ALL 3 FORMS)

NAME/NOMBRE:			D.O.B/Fecha de nacimiento
MAILING ADDRESS/ DIRECCIÓN DE ENVIO	CITY/ CIUDAD	STATE/ ESTADO	ZIP CODE/CODIGO POSTAL

PREVIOUS MAMMOGRAM/ Mamografia Anterior: Yes ☐ No ☐ Where/Dónde: When/Cuando:

REASON FOR EXAM—PLEASE CHECK ONE/ RAZÓN PARA EL EXAMEN - POR FAVOR MARQUE UNO:

☐ Routine Yearly Screening/Revisión Anual de Rutina

☐ Call Back For Additional Imaging/Devolver la llamada para una evaluación adicional

☐ New Breast Problems Since Last Mammogram/ Nuevos problemas de mama desde la última mamografía

	NO	YES	*Which Breast/ que mama?* RIGHT	LEFT
Do you have any **NEW** lump(s) in either breast/	____	____	____	____
Tiene alguna (s) nueva (s) protuberancia (s) en cualquiera de los senos?	____	____	____	____
Pain or Discomfort/dolor o malestar?	____	____	____	____
Discharge from nipple/secreción del pezón: Color __________	____	____	____	____

Other:

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING/ POR FAVOR, COMPRUEBE SI HA TENIDO ALGUNO DE LOS SIGUIENTES:

	NO	YES	*Which Breast/ que mama?* LEFT	RIGHT	WHEN
Mastectomy/ mastectomía:	____	____	____	____	____
Cancerous Breast Lump Removed/ tumor tumoral canceroso eliminado:	____	____	____	____	____
Radiation/ radiación:	____	____	____	____	____
Chemotherapy/ quimioterapia:	____	____	____	____	____
Cyst Aspiration For Fluid/ aspiración de quistes para líquido:	____	____	____	____	____
Biopsy (Normal/ Negative)/ biopsia (negativa / normal):	____	____	____	____	____
Augmentation (Implants)/ aumento (implantes):	____	____	____	____	____
Reduction/ reducción:	____	____	____	____	____

Previous Cancer- What Type? / cáncer anterior- qué tipo: __________ __________

Number of Pregnacies/ cantidad de embarazos:_____ Date of last period or hysterectomy/ fecha del último período ohisterectomía:_____

Age At First Period/ edad en el primer período:_____ Age At First Delivery/ edad en la primera entrega:_______

Age At Menopause/ edad en la menopausia: _______ Are you taking hormones/ ¿Estás tomando hormonas? Ye☐ No☐

If Yes, How long/ Si es así, ¿cuánto tiempo?_______

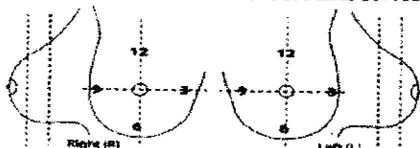
Family History Of Breast Cancer/ Antecedentes familiares de cáncer de mama:

☐ Mother/Madre ☐ Sister/Hermana ☐ Daughter/hija ☐ Aunt/ Tia ☐ Grandmother/ Abuela ☐ Other/otro ☐ None/ninguna

THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

______________________________________ ______________________

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO CONSENT FOR PATIENT **DATE:**



RIGHT **LEFT**

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____
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____
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South ATLANTA RADIOLOGY ASSOCIATES

P. O BOX 961930

RIVERDALE, GA 30296-1930

Mammogram Informed Consent Form

Please READ carefully, **SIGN** and **DATE** the form.

- I understand that a mammogram is only 90% accurate in detecting breast cancers and is only a partial examination for diagnosing breast cancers.
- I understand based on my clinical symptoms I may be referred for additional mammogram films, an ultrasound or to a surgeon.
- I understand periodic breast examination should be done by a physician.
- I understand, if after seeing my physician, I continue to have breast problems, regardless of a negative report on the mammogram, I will contact my physician for instructions on further follow-up.
- I understand some REDNESS and/ or TENDERNESS of my breast may occur following the mammogram due to the compress device necessary for good images, but these symptoms should be gone within 24-48 hours.
- I understand a mammogram does require the ***use of low dose radiation:*** **therefore, I will inform the Technologist if I THINK I AM PREGNANT.**
- I understand the results are not given the same day mammogram is taken. I will receive my results by letter in 7 -10 business days from this office. My physician will receive my results in 3-5 business days.
- If I have not received my results in 30 days, I will contact South Atlanta Radiology Associates at 770-991-1010.
- If the results of my mammogram warrant a surgical consultation or breast biopsy, I authorize the physician, hospital, laboratory or other facility to release the results of consultation or pathology report South Atlanta Radiology Associates.

PATIENT'S SIGNATURE: ______________________________ DATE: ____________

PATIENT (PRINT NAME): ______________________________

DATE OF BIRTH: ______________________________

TECHNOLOGIST: ______________________________