Thank you for choosing Baylor Diagnostic Imaging Center and The Women’s Imaging Center for your upcoming procedure(s). Baylor Medical Center at Carrollton respects your time and strives to provide you with very good care. To help expedite the registration process and reduce your wait time in registration, please bring the following completed items with you to your appointment:

- Completed Outpatient Pre-Registration forms for your scheduled test or procedure
- Women's Imaging Center Breast Questionnaire
- Outpatient Questionnaire/ Falls Assessment
- Radiology Screening, Childbearing Age (females 12-55 years of age only)
- Ionizing Radiation Pregnancy Consent for Treatment (females 12-55 years of age only)

- Insurance Card
- Government Issued Identification
- Insurance co-payment
- Physician orders, if applicable

Baylor Diagnostic Imaging Center at Carrollton and The Women’s Imaging Center provide many diagnostic and screening procedures. Every procedure is overseen by a specialist who will provide patient-centered care. As people are all different, the amount of time each individual needs for their procedure is also different. Please don’t be concerned if you are taken to the testing area before someone who arrived prior to you. We will strive to provide each patient with the specialized care they deserve which can cause some fluctuations in the amount of time needed for each test. We will be sensitive to the needs of all of our patients - all of the time.

Below is the average amount of time spent in the testing area for the most common procedures:

- Screening Mammograms: 20 minutes
- Diagnostic Mammograms: 60 minutes
- CAT Scans: 30 minutes
- X-Rays: 15 minutes
- MRI: 45 to 60 minutes
- Bone Density Screenings: 15 minutes
- Biopsy: 90 to 120 minutes

Please understand these are average times and could vary.
## WOMEN'S IMAGING CENTER BREAST QUESTIONNAIRE

*All replies are confidential. Please circle YES or NO and answer ALL questions.*

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Your Age</th>
<th>Address: (Please list an address where mail will always reach you) City, State, Zip</th>
<th>Phone: (Please list a number where we can always reach you)</th>
</tr>
</thead>
</table>

### Medical History

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had a mammogram or breast ultrasound before?</td>
<td>Yes, No</td>
<td>If Yes, <strong>when</strong> (approximate dates)? <strong>Where</strong> and at which facility: ______________________________ Are your films still there? YES NO</td>
</tr>
<tr>
<td>Have you had a mammogram in the last year?</td>
<td>Yes, No</td>
<td>Since your last mammogram, are there any <strong>new lumps</strong> in your breast? If YES, <strong>when</strong> was it first noted ________</td>
</tr>
<tr>
<td>Any discomfort, pain or soreness?</td>
<td>Yes, No</td>
<td>If YES, in which breast: Right Left Both Is this a new problem? YES NO How long have you had this pain?</td>
</tr>
<tr>
<td>Is either nipple retracted / inverted?</td>
<td>Yes, No</td>
<td>Is either nipple retracted / inverted? If YES, in which breast: Right Left Both Has it always been retracted? YES NO</td>
</tr>
<tr>
<td>Any crusting or sores at the nipple(s)?</td>
<td>Yes, No</td>
<td>Any crusting or sores at the nipple(s)? Right Left Both</td>
</tr>
<tr>
<td>Any discharge from nipples?</td>
<td>Yes, No</td>
<td>Any discharge from nipples? If YES, in which breast: Right Left Both</td>
</tr>
<tr>
<td>Discharge in clothing?</td>
<td>Yes, No</td>
<td>Do you see it in your clothing? YES NO Has the discharge ever been bloody? YES NO</td>
</tr>
<tr>
<td>Have you had Breast Cancer?</td>
<td>Yes, No</td>
<td>Have you had Breast Cancer? If YES, in which breast: Right Left Both Did you have radiation? Mastectomy? When did you complete treatment?</td>
</tr>
<tr>
<td>Have you had a previous breast surgery, biopsy or a needle aspiration?</td>
<td>Yes, No</td>
<td>Have you had a previous breast surgery, biopsy or a needle aspiration? Approximate date(s):</td>
</tr>
<tr>
<td>Do you have any breast implants now or have you had any augmentations in the past?</td>
<td>Yes, No</td>
<td>If YES, in which breast: Right Left Both What symptoms did you have?</td>
</tr>
<tr>
<td>Any family history of breast cancer?</td>
<td>Yes, No</td>
<td>Any family history of breast cancer? Did it occur before menopause? YES NO (or about what age?) In which relative(s)? Mother Sister Daughter Other: ______________________________</td>
</tr>
<tr>
<td>Do you take female hormones?</td>
<td>Yes, No</td>
<td>Do you take female hormones? (please circle) Premarin, Provera, PremPro, Prometruim, or birth-control pills? If YES, for how long? Recent Increase or Decrease (please circle) in the dosage?</td>
</tr>
<tr>
<td>Could you be pregnant at this time?</td>
<td>Yes, No</td>
<td>Could you be pregnant at this time? If NO, why not?</td>
</tr>
</tbody>
</table>

### Personal History

- You have borne how many children? _______ Did you breast feed any of your children for longer than one month? YES NO
- At what age was your first pregnancy? _______ Do you still have menstrual periods? NO If YES, when was your last one?

### Additional Information

<table>
<thead>
<tr>
<th>Name and address of your physician(s) (Who ordered this exam? OR Who should receive the written report?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Fax:</td>
</tr>
</tbody>
</table>

### Administrative Information

<table>
<thead>
<tr>
<th>Time check in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appoint. Time</td>
</tr>
</tbody>
</table>

---

*REV. 11/21/07*
FOR OFFICE USE ONLY

- Baseline
- Previous films with TMC
- New Patient
- Patient has a release form to obtain prior study

<table>
<thead>
<tr>
<th>Patient’s Last Name</th>
<th>First Name</th>
<th>Age</th>
<th>Exam Date</th>
<th>Tech’s Signature</th>
</tr>
</thead>
</table>

Reason for Exam / Comments:

Procedures:
- Routine
- Call Back RT
- Call back LT
- Call back Bilateral
- Ultrasound RT
- Ultrasound LT
- Ultrasound Bilateral
- Cyst Aspiration
- Core BX
- Needle Localization
- Ductogram

Addendum:
- Comparison with prior study
- Review of outside study
- Unable to get prior study
- Pathology / Specimen
- Other

Breast Density:
- Very Dense
- Dense
- Average
- Fatty

<table>
<thead>
<tr>
<th>IMPRESSION</th>
<th>RECOMMENDATION</th>
</tr>
</thead>
</table>
| Incomplete needs Additional imaging evaluation BI-RAD 0
| Follow up mammogram in ________ yr ________ mos | RT | LT |
| At age 40 | No follow up | Back on schedule |
| Negative BI-RAD 1
| Special view(s) | RT | LT | now | mos |
| Spot comp. | Mag | ML | LM | CC | NIP | CLEO |
| Benign BI-RAD 2
| Ultrasound | RT | LT | now | mos |
| Clinical Exam | _____ by us | _____ by clinician |
| Probably benign finding BI-RAD 3
| Aspiration |
| Suspicious BI-RAD 4
| Core Biopsy |
| High suggest of Malign BI-RAD 5
| Surgical Consultation |
| Obtain Prior Study |

Radiologist: ____________
Radiologist: ____________

Date Read: ____________________
Date Entered MRS ____________________ By: ____________________
Multi-reading or Compare with prior mammogram.

*«PatientNumber»*
ACCT# «PatientNumber» MR# «MedicalRecordNumber» «AdmitDate» «PatientName»
OUTPATIENT QUESTIONNAIRE / FALLS ASSESSMENT

Please answer the following questions:

Fall Risk Assessment

Yes  No
☐  ☐  Do you feel unsteady when you walk?
☐  ☐  Do you use anything to help you walk?
☐  ☐  Have you had any recent falls or near falls?
☐  ☐  Have you taken any medications today that make you drowsy or dizzy?

What is one thing that I can do for you to make sure that you get very good care today?

________________________________________________________________________

Are there any special needs/considerations that we should know about?

________________________________________________________________________

________________________________________________________________________

Patient Signature ___________________________________________ Date ________ Time ________

Authorized Representative ___________________________________________ Relationship ___________________________ Date ________ Time ________

FOR STAFF USE ONLY:

☐  Patient is at high risk for falls. (Check if any answer above is ‘Yes’.)

Actions Taken:

☐  Patient given facility specific fall precaution identification.
☐  Escorted Patient under their own power.
☐  Escorted Patient by wheelchair.
☐  Patient used their own cane/walker or other device.
☐  Instructed Patient that a staff member should be present each time they ambulate while in the facility.

STAFF SIGNATURE ___________________________________________ DATE ________ TIME ________
This form must be completed for/by all female patients who have menstruated and could possibly be or become pregnant. Although most standard radiology procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending upon the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy. The following information will help your health care provider assess and discuss with you the risks, benefits, and alternatives of performing or postponing the radiology procedure that has been ordered by your physician or whether a different or limited radiology procedure is available. This form will be retained with your medical records. The information provided by you will be used or disclosed only in accordance with federal or state law.

Name__________________________________________

LAST          FIRST          MIDDLE

Date of Birth: _______ / _______ / _______    Age: _______

Date of Last Menstrual Cycle: _____________________________

1. Are you pregnant? □ Yes □ No □ Maybe
2. Could you be pregnant? □ Yes □ No □ Maybe
3. Are you currently breast feeding? □ Yes □ No
4. Do you have history of a tubal ligation, and/or a hysterectomy and/or menopause? □ Yes □ No

I have read and understood the above information and the above information is correct.

______________________________________________  ____________________________  ____________________________
Signature Patient/Legal Representative       Date        Time

______________________________________________
Printed Name Patient/Legal Representative
IONIZING RADIATION PREGNANCY
CONSENT FOR TREATMENT

Female patients who are pregnant or suspect that they may be pregnant should not have an exam that utilizes ionizing radiation unless the patient's ordering physician determines the exam is medically necessary and the patient consents to the exam after having had the risks, benefits, and alternatives explained. If possible, confirmation of pregnancy/non-pregnancy for females who could possibly be or become pregnant is important prior to performing an ionizing radiological exam. Although most standard ionizing radiation procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending on the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy.

I. UNCLEAR PREGNANCY STATUS (Please check and initial all that apply below)

- I am unsure of my pregnancy status
  - Patient Initials

- I have decided to delay or reschedule the exam/procedure until my pregnancy status is confirmed. Facility staff will notify my ordering physician of the delay or rescheduling of my exam.
  - Patient Initials

- I am requesting that the facility perform a pregnancy test at my expense.
  - Patient Initials

- I am unsure of my status and have declined a pregnancy test. I have decided to have the exam with ionizing radiation and I understand the risks, benefits, and alternatives involved.
  - Patient Initials

By signing below I agree that these statements are true: (a) I've had the opportunity for a physician to discuss the risks, benefits, and alternatives of the ionizing radiation procedure/exam with me, (b) I have had the opportunity to ask questions of the physician, and (c) I hereby release the Baylor Health Care System and this facility from any complications that may occur from my decision to delay, reschedule or undergo the ionizing radiation procedure/exam.

Signature Patient/Legal Representative
Printed Name Patient/Legal Representative
Date
Time

II. POSITIVE PREGNANCY STATUS (Please check and initial all that apply below)

- I am pregnant or have had a positive pregnancy test, and I have decided to delay or reschedule the exam/procedure until I have had a chance to discuss this exam further with my referring physician.
  - Patient Initials

- I am pregnant and I have consented to undergo the exam with ionizing radiation with the knowledge of the risks, benefits, and alternatives to my unborn fetus and I understand the risks, benefits, and alternatives involved.
  - Patient Initials

By signing below I agree that these statements are true: (a) I’ve had the opportunity for a physician to discuss the risks, benefits, and alternatives of the ionizing radiation procedure/exam with me, (b) I have had the opportunity to ask questions of the physician, and (c) I hereby release the Baylor Health Care System and this facility from any complications that may occur from my decision to delay, reschedule or undergo the ionizing radiation procedure/exam.

Signature Patient/Legal Representative
Printed Name Patient/Legal Representative
Date
Time

CONSENT-IONIZING RADIATION
PREGNANCY

REV: 07/22/2010