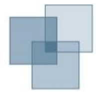

MT BAKER IMAGING

WOMEN'S DIAGNOSTIC CENTER

Mammography Prior Imaging Request

Phone: (360) 788-9105 Fax: (360) 752-0979

Patient Name: ________________________________ **Date of Birth:** ______________

Maiden or Previous Name(s):______________________________________ SSN: __________________

I hereby authorize Mt Baker Imaging to obtain medical records, including images and reports, from the below-names facility:

Prior Imaging Facility:

Facility Name: ____

Address: ____

City: __________________________________State________ Zip: ________________

Exams Requested for Comparison Purposes (continuation of care):

☐ Mammograms ☐ Breast Ultrasound ☐ Breast MRI

☐ Breast Biopsies ☐ Other____

Share Electronically (Preferred Method):	Or Mail DICOM Formatted CD:	Fax Reports:
☐ Upload via our secure ImageShare Portal: http://mbi.ambrahealth.com/share/mbi_upload -or- ☐ eMix (eMix@nwrads.com) -or- ☐ PeaceHealth PACS (AE title: PHOUTPACS)	Mt Baker Imaging Women's Diagnostic Center 4029 Northwest Ave. #101 Bellingham, WA 98226	(360) 752-0979

Please call (360) 788-9105 if:

☐ Patient had exam but no images are available
☐ There is no record of breast imaging for this patient
☐ Other____

____ ____________________

Signature of Patient/Patient Representative Date

Office use only

Facility Phone: ___________________________ Fax: ___________________________________ Attention:________________________________