

# WHASN Mammography Center

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_

## PHYSICIAN INFORMATION

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## REASON FOR ORDER

Annual SCREENING mammogram

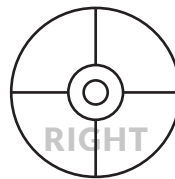
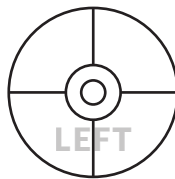
DIAGNOSTIC mammogram with ultrasound, if needed

Left

Right

Bilateral

Mark area(s) of concern



Breast ultrasound

WHASN  
Mammography  
Center | at Lake Mead

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WHASN  
Mammography  
Center | at Meadows

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