



Dear Client,

The radiologist would like to compare your prior mammogram films with the recent mammogram. This is a routine procedure when a person has had a mammogram at another facility.

If you have not already done so, please complete and sign the form below. Verify your name and birth date and mail, fax or deliver this form to the facility where you had your last mammogram.

Facility where last mammogram was done

Re: Your name at time of mammogram: _____
(Please Print)

Date of birth: _____

Year of last mammogram: _____

Kindly send my films to:

HIGHPOINT HEALTH
BREAST CARE CENTER
606 WILSON CREEK RD STE 120
LAWRENCEBURG, IN 47025
PHONE: 812-537-8383
FAX: 812-537-8464

**PLEASE SEND IMAGES ON
A DICOM COMPATIBLE DISK
WITH A COPY OF THE REPORT.**

THANK YOU,

Signature

Date