

Outside Read Mammography Request Form

Name: _____ DOB: _____

Telephone: (____) _____

Address: _____

City, State, Zip: _____

Method of Payment: Circle One Insurance Cash/Check/Card

Insurance Company: _____

Insurance ID #: _____ Group #: _____

Date of Mammography: _____

Place Performed: _____

Please provide your Primary Care Physician information below:

Special Concerns:

*Images, initial report from provider, as well as prior mammography exams (if any) must be provided by the requesting individual to Siker Medical Imaging and Intervention, 1800 NE 2nd Ave. Portland, OR 97212.

Please fill out and fax form to 503-595-3937. Results are returned within one business week.