

**Mallinckrodt Institute of Radiology
Barnes-Jewish Hospital / Barnes-Jewish West County Hospital
Request for Contrast-Enhanced Breast MRI**

Patient Name _____ DOB _____

Referring Physician _____ Attn _____

Physician Office Phone _____ Physician Office Fax _____

Reason for MRI Request

- High Risk Screening (choose one of the following)
- BRCA mutation or first-degree relative of BRCA carrier
 - Lifetime risk > 20-25%. Must include risk assessment score and method
Lifetime risk _____ % Risk assessment tool used _____
- Recent diagnosis breast cancer by
- Large core needle biopsy Surgical biopsy **Attach copy of reports**

Mammogram: If patient's mammo > 1 year old, obtain mammogram before requesting MRI
_____ **Attach copy of report**

Has the patient had an ultrasound of the breast? Yes No **Attach copy of report**

Has the patient had a previous MRI of the breast(s)? Yes No
If so, where? _____ **Attach copy of report**

Has the patient had a prior reaction to iodinated contrast material? Yes No

If "yes," did the reaction result in a compromised airway, marked drop in blood pressure,
or other potentially life threatening problem? Yes No

Patient's current weight _____

Patient's current creatinine level _____ (Must be drawn within 90 days of MRI with **report attached**)

MD Signature _____ Date _____

FAX the completed form with reports (see above) to **314.747.1652**

Once received, a radiologist will review this request, and you will be notified by fax or called by a radiologist for additional information.

All patients who do not have Barnes-Jewish Hospital films must bring ALL outside mammograms and breast ultrasounds on the day of the examination. Failure to do so will result in cancellation of the exam.