

Rex Mobile Mammography Patient Instructions

All patients must be pre-registered. Please fax documents directly to the Rex Mobile Mammography office at (919) 784-4205.

To be eligible for screening, you must:

- Have a physician.
- Be 35 years of age or older
- Have no previous history of Breast Cancer.
- No present symptoms such as pain, lumps, or nipple discharge.
- Do not have breast implants.
- May not be pregnant.

Please verify with your insurance company for coverage:

- If you are **under 40** years of age.
- It has not been 12 months since your last mammogram.

- **Please be sure to include the full name, address and phone number of your physician on registration form.** All patients **must** have a physician.
- **Please also be sure to indicate where you had your last mammogram.** If your previous mammogram was with Rex, please indicate it on the form.

Prior to your appointment, call the mammography facility and have them send your last mammogram films and report to: Rex Mobile Mammography, c/o Breast Care Center, 2800 Blue Ridge Road, Suite 204, Raleigh, NC 27607

If you are uncertain about your previous mammography facility, please call your physician's office and have them check your medical record report.

Attention to these guidelines will help us greatly in the registration process and will reduce the wait time on the day of your exam. Thank you for choosing Rex Mobile Mammography to provide your annual mammogram.

If you have any questions, contact your site coordinator, or you may call Rex Mobile Mammography at (919) 784-4210.



Rex Mobile Mammography Pre-Exam Form

All patients must also be registered through the site coordinator:

Time: _____ Date of appointment: _____

Registration Information:

Name (Last, First, Middle): _____

DOB: _____ Race: _____ Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mother's Maiden Name: _____

Last Four of Social Security #: _____ Marital Status: _____

This must be completed to schedule an appointment.

Physician Information:

Name of Physician: _____

Name of Practice: _____

Address (in full): _____

Phone: _____ Fax: _____

Insurance Information (attach a copy of your insurance card)

Are you enrolled in an insurance plan? ___yes ___no

If no, please complete certificate questionnaire.

If yes, please attach insurance card.

Have you ever been to Rex Hospital: ___yes ___no

Breast Health Information:

Reason for today's mammogram: Routine _____ Other _____

Family history of breast cancer? ** Please give relationship and age diagnosed.

Date of your last menstrual period: _____

Number of pregnancies: _____ Age at first Pregnancy: _____

Are you currently taking hormones? _____

Are you currently taking birth control pills? _____

Have you had any breast surgeries (including augmentation) or biopsies? _____

If so, list, date: _____ type: _____ side: _____

result: _____

Last Mammogram:

Where: _____

When: _____

Date of last clinical breast exam? _____

