



Outside Facility Mammography Exam Request Form

Date: _____

Name & Address of Facility: _____

Phone No.: _____ Fax No.: _____

The following patient:

Name: _____

DOB: _____ LC No.: _____

is requesting their mammogram studies be sent to Lahey Hospital & Medical Center.

Please send previous years _____ of Mammography
and Breast Imaging exams by CD/disc and include paper copies of reports if possible.

**Lahey Hospital & Medical Center
41 Mall Road
Burlington, MA 01805
Image Management Center
Attn: Mammography Department**

Fax: 781.744.3738, Phone: 781.744.8917

Patient Signature: _____

Previous Name: _____

Patient Phone No.: _____