



Outside Facility Mammography Exam Request Form

Date: _____

Name of Outside Facility _____

Address _____

Phone# _____ Fax# _____

The following patient _____

DOB: _____ LC# _____

is requesting their mammogram studies be sent to the facility listed below.
Please send the five most recent mammography exams and reports along with
this form. Please send paper copies of reports.

****Please send digital mammograms by way of CD if possible****

**Lahey Outpatient Center, Lexington
Breast Imaging Department
C/O Krissy Mallinson
16 Hayden Ave.
Lexington, MA 02421
(781)372-7035**

Thank You.

Breast Imaging Department, Lahey Outpatient Center Lexington

Patient Signature: _____

Previous Name _____

Patient Phone# _____

Patients and Physicians
*Please fax or mail this completed form, including patient signature, to
the Breast Imaging Department if you would like us to obtain these
films for you. Fax # (781)372-7166*

Patient would like digital copies/ CDs returned to home address

Patient would like digital copies/ CDs destroyed after use

Tech Initials:



Lahey Outpatient Center
Lexington

16 Hayden Avenue
Lexington, MA 02421

781.372.7035 P
lahey.org

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