SHEILA R. VELOZ BREAST CENTER
A SERVICE OF HENRY MAYO NEWHALL HOSPITAL

23929 McBean Parkway, Suite # 101, Valencia, CA 91355-2083
PHONE: (661) 200-1099
FAX: (661) 200-1098

SURGEON NAME: TODAY'S DATE:

PATIENT NAME:

DOB: PHONE #:

PROCEDURE DATE: TIME:

INJECTION DATE: TIME:

****CALL HENRY MAYO RADIOLOGY TO SCHEDULE TC-99 AT 661-200-1650****

SURGERY DATE: TIME:

SURGERY SPECIFICATIONS

CLOCK FACE: # OF LESIONS: BRACKET? ☐ YES ☐ NO

BIOPSY CLIP SHAPE (IF KNOWN): PATHOLOGY:

LATERALITY: ☐ LEFT ☐ RIGHT SURGERY LOCATION:

PROCEDURE

☐ MAGSEED LOCALIZATION ☐ TUFLEX LOCALIZATION

☐ MAGTRACE INJECTION

☐ ULTRASOUND MARKING

☐ WIRE LOCALIZATON

☐ TC-99 INJECTION (LYMPHOSEEK)

SPECIAL INSTRUCTIONS:

OUTSIDE IMAGES FROM (FACILITY):

HOW ARE IMAGES BEING DELIVERED?

SCHEDULED WITH: DATE:

****PHYSICIAN SIGNATURE****

THIS AREA TO BE FILLED OUT BY SHEILA R. VELOZ

IMAGES RECEIVED AT BIC BY: DATE:

RADIOLOGIST PLEASE COMPLETE:

☐ MAMMOGRAM

☐ ULTRASOUND

OF LESIONS:

PATHOLOGY:

LOCATION/CLIP SHAPE:

INITIALS:

BOOKED BY: DATE: