Oklahoma County Health Plan Participants:

Save the Date

OK County Employees

Mammography Day

Scheduled for Thursday, November 19, 2015

Don't miss this chance to be pampered

3D Digital Mammography*
Upscale Transportation
10 Minute Results
Refreshments
Mini Shoulder/Neck Massage
and More!

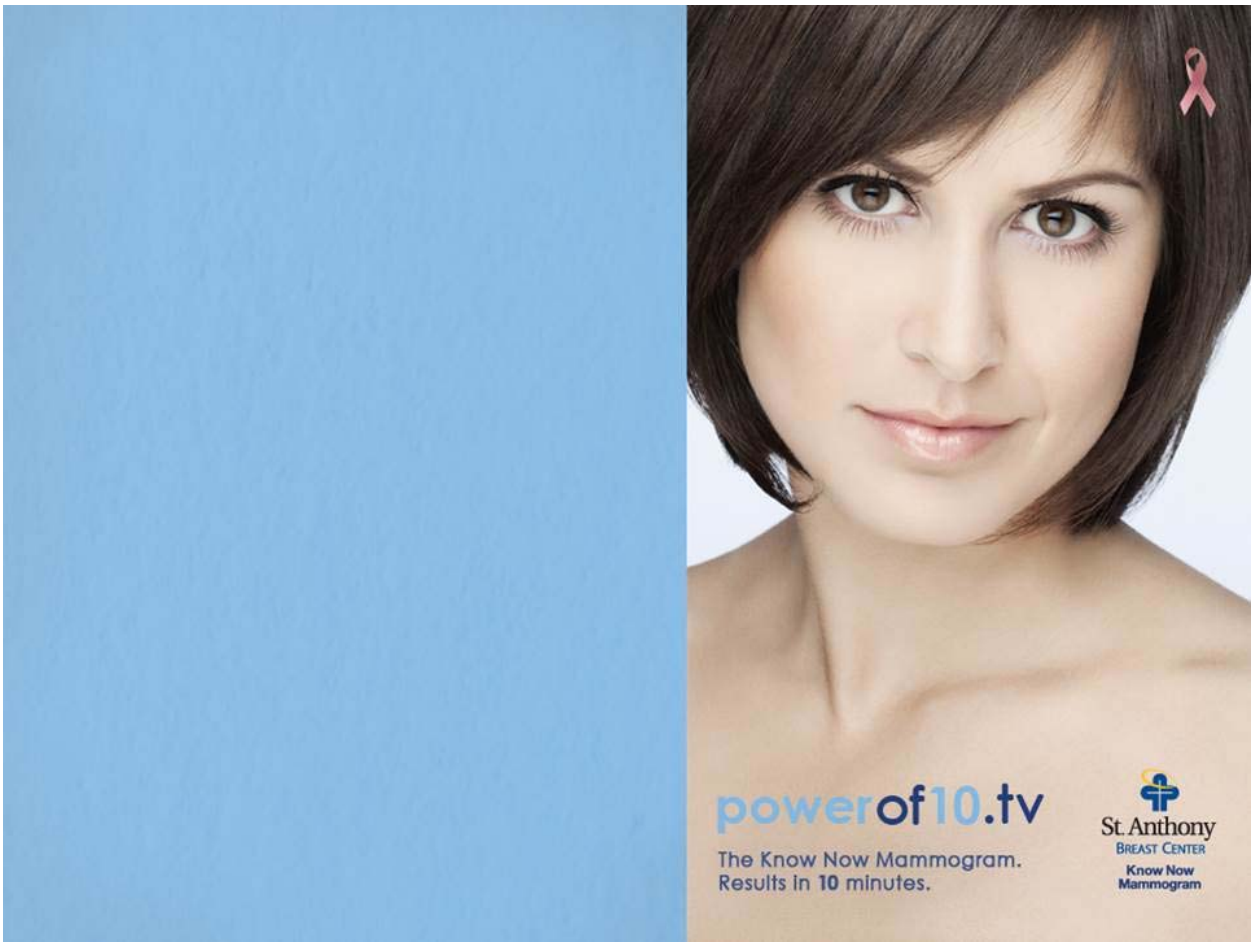
To sign up, email Le Nguyen by November 2, 2015
lnguyen@oklahomacounty.org

Fax, or email, your Mammography paperwork to 405-272-8407, or Shannon_wood@ssmhc.com

*Additional charges may apply

For questions, please contact: shannon_wood@ssmhc.com

St. Anthony's will pick-up participants in front of the Oklahoma County Annex building located at: 320 Robert S. Kerr



St Anthony Hospital
Mammography Worksheet

Last _____ First _____ MI ____ DOB _____ Age _____

**Physician _____

**A PHYSICIAN MUST BE PROVIDED TO PARTICIPATE

Mailing Address _____

Home phone _____ Work Phone _____

Cell phone _____ E-mail _____

Personal Risk Factors

		Age			Age
☐	Breast cancer gene	_____	☐	History of endometrial cancer	_____
☐	History of breast cancer	_____	☐	History of high-risk lesion	_____
☐	History of ovarian cancer	_____	☐	History of colon cancer	_____

Family History of Breast Cancer

Relative	Age
_____	_____
_____	_____
_____	_____

Breast Surgical and Treatment History: Include date, type, and result

_____

_____

Breast Implants

Right	☐	Date _____	Silicone Gel _____	Saline _____
Left	☐	Date _____	Silicone Gel _____	Saline _____

Hormone History

Currently Using	Age at First Use	Age at Last Use	Duration of Use	
Estrogen	_____	_____	_____yrs	_____months
Progesterone	_____	_____	_____yrs	_____months
Tamoxifen	_____	_____	_____yrs	_____months
Raloxifene	_____	_____	_____yrs	_____months
Unspecified hormones	_____	_____	_____yrs	_____months

Current Complaints/Symptoms:

_____

☐ First mammogram Time since last mammogram _____yrs _____months

Location of last mammogram: _____

Signature _____

St Anthony Hospital
Mammography Worksheet

Emergency Contact Information

Name:	Relationship:
Address:	
Home Phone:	Cell Phone:
Employer:	Work Phone:
Employer Address:	

Insurance Information

Primary Insurance Name:	Secondary Insurance Name:
Address:	Address:
City State Zip	City State Zip
Name as it is on card:	Name as it is on card:
Policy# Group#	Policy# Group#
Policy Holder's SSN# (last 4 digits) xxx-xx-	Policy Holder's SS # (last 4 digits) xxx-xx-
DOB:	DOB:
Medicare Number:	Medicare Number:
Name as it is on card:	Name as it is on card:

PLEASE PROVIDE COPY OF INSURANCE CARD (FRONT & BACK) AND DRIVER'S LICENSE

St Anthony Hospital
Mammography Worksheet

PLEASE COMPLETE & SIGN BELOW ONLY IF YOUR PREVIOUS MAMMOGRAM WAS NOT PERFORMED AT ST ANTHONY*

Last:_____ First _____

Other Names Used: _____

SS#: _____ DOB: _____

Records Requested: Mammograms & Reports Breast U/S & Reports Breast MRI & Reports

(**X**) Mail copies of records (***CD's are gladly accepted***) to the facility noted below:

Records From:	**Records To:**
Facility Name: _____	**Breast Center at St Anthony Hospital**
Facility City & State: _____	**535 NW 9th Ste 100, OKC, OK 73102**
Phone: _____	Phone: (405) 272-4226
Fax: _____	Fax: (405) 272-8407

Purpose of request: __X__ Patient's request, __X__ Comparison,

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be one (1) year from the date of the signature.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and Human Immunodeficiency Virus also known as Acquired Immune Deficiency Syndrome (AIDS)

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Mammography Worksheet

Signature of Patient, Parent, or Legally Authorized Rep.	Relation to Patient	Date