Hartford Hospital
A Hartford HealthCare Partner

FAX/SCAN COVER SHEET MOBILE SCREENING MAMMOGRAPHY PROGRAM

DATE: _____

TO: Mobile Mammography Registrar

FAX: 860-545-1118

PATIENT'S NAME: _____
(Please Print Legibly)

LOCATION OF MAMMOGRAM: _____

DATE & TIME OF APPOINTMENT: _____

Please fax or scan your completed INTAKE FORM to us using this fax cover sheet at least 14 days prior to your scheduled mammogram. Please indicate the location and date of your last mammogram below.

Is this your first mammogram? _____

If not, date of your last mammogram _____
It must be **at least 12 months and one day** since your last mammogram

Where did you have your last mammogram? _____
(Name of imaging center and town)

Please give us a call at 860-972-1243, if you have any questions in regards to registration. We look forward to seeing soon. Thank you.

Hartford Hospital
Mobile Mammography Team