

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