



Request for prior Mammography/Breast US imaging

Patient name: \_\_\_\_\_ Date of birth \_\_\_\_\_

Prior facility name: \_\_\_\_\_

Facility phone number: \_\_\_\_\_

Facility Fax Number \_\_\_\_\_

Notes: \_\_\_\_\_

Office: Please send a DICOM disc to the Weems Memorial Hospital  
Mammography Department at the address below and fax reports to

FAX 850-653-8349

Phone 850- 653-8853 Ext: 119

Weems Memorial Hospital

135 Avenue G

Apalachicola, Fl. 32320

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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