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: 1190

Weems Memorial Hospital

135 Avenue G

Apalachicola, Fl. 32320

Patient Signature: _____ Date: _____

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