

PRE-SURGICAL BREAST WIRE-LOCALIZATION FORM

Patient Name:

MRN # :

Date of Birth:

(Place Patient Label Here)

Exam Date/Time:

Wire Placed By (circle one): **Ultrasound** or **Mammography**

Length of the wire used:

Length of the wire from skin surface to the tip of the wire:

Size of the lesion(s) or calcifications:

Distance of the lesion(s) or calcifications from the tip of the wire/relationship of lesion to the wire:

Depth of the lesion(s) or calcifications from the closest skin surface to the lesion:

Radiologist Signature: