Your Hospital's Logo Here

WELLNESS INSTITUTE & MAMMOGRAPHY CENTER

Street Address
City, State Zip

MAMMOGRAM FILM RECEIPT

PATIENT'S NAME:	DATE OF BIRTH:
HOME TEL: ( ) -	WORK TEL: ( ) -

DATE RECEIVED:

☐ HAND DELIVERED ☐ MAILED

HOW MANY SETS -and- WHAT IS THE YEAR FOR EACH SET RECEIVED?

PATIENT'S SIGNATURE:	**STAFF'S SIGNATURE:**

RETURNING OF FILMS UPON COMPLETION

Would you like to leave your films here ? ☐ YES ☐ NO

DATE FILMS RETURNED TO PATIENT:	**STAFF'S SIGNATURE:**
☐ Someone other than Patient picking-up films? *(If so, complete questions below)*	**PATIENT'S SIGNATURE (upon receipt of films):**

RELATIONSHIP TO PATIENT:

PERSON'S NAME:	**PERSON'S SIGNATURE:**