WOMEN’S IMAGING REQUEST FORM

Call (540) 932-4486 OR (540) 332-4486
FAX (540) 932-5100
Locations: Fishersville, Staunton, and Stuarts Draft
Please give 24-hour notice for cancellation

It is very IMPORTANT that you take this form with you to your appointment. If you DO NOT have this form, mammography may reschedule your appointment.

Appointment Date ___________________________ Time ___________________________

Location: [ ] Women’s Imaging (at hospital) [ ] Staunton [ ] Stuarts Draft

Patient Name: ____________________________ Date of Birth: __________________

[ ] COMPREHENSIVE BREAST CARE ORDER: by checking this box the referring provider authorizes the Women’s Imaging Center to perform ANY of the tests listed below without requiring additional orders from the provider. Referring provider will be notified if any further procedures are needed.

- Screening Mammogram [ ] Bilateral [ ] Right [ ] Left
- Diagnostic Mammogram [ ] Bilateral [ ] Right [ ] Left
- Breast Ultrasound [ ] Bilateral [ ] Right [ ] Left
- Axillary Ultrasound [ ] Bilateral [ ] Right [ ] Left
- Stereotactic Breast Biopsy [ ] Bilateral [ ] Right [ ] Left
- Ultrasound Guided Core Biopsy [ ] Bilateral [ ] Right [ ] Left
- Ultrasound Guided Cyst Aspiration [ ] Bilateral [ ] Right [ ] Left
- Ultrasound Guided Axillary Lymph Node Biopsy [ ] Bilateral [ ] Right [ ] Left
- Galactogram [ ] Bilateral [ ] Right [ ] Left
- Breast MRI [ ] Bilateral [ ] Right [ ] Left
- MRI Guided Breast Biopsy [ ] Bilateral [ ] Right [ ] Left
- Needle localization Biopsy [ ] Bilateral [ ] Right [ ] Left
- Needle localization Biopsy w/ Nuc Med Sentinel Node [ ] Bilateral [ ] Right [ ] Left
- Other (specify) ____________________________ [ ] Bilateral [ ] Right [ ] Left

Diagnosis for Diagnostic Mammogram/Breast Ultrasound (Mark area of concern)
________________________________________________________________________
________________________________________________________________________

[ ] Dexa-Bone Density/Diagnosis

***STOP CALCIUM, ANTACIDS, VITAMIN D/D3, AND MULTIVITAMINS 48 HOURS PRIOR TO DEXA***

Physician Use

Physician Signature ____________________________ Date ____________________________ Time ____________________________

For Mammography Staff to Complete

[ ] Baseline [ ] Previous Mammogram ____________________________

Family/Personal History of Breast Cancer ____________________________

Surgical History: ______________________________________________________

Other Information: ______________________________________________________

Technologist Signature: ____________________________ Date/Time: ____________________________

March 2018