



**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

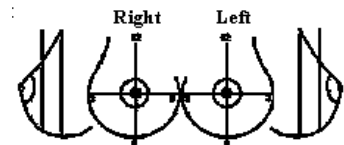
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

[ ] **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)

\_\_\_\_\_  
\_\_\_\_\_



Physician Use

[ ] DEXA-Bone Density/Diagnosis \_\_\_\_\_  
\*\*\*STOP CALCIUM, ANTACIDS, VITAMIN D/D3, AND MULTIVITAMINS 48 HOURS PRIOR TO DEXA\*\*\*

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

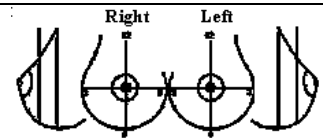
**For Mammography Staff to Complete**

[ ] Baseline [ ] Previous Mammogram \_\_\_\_\_

Family/Personal History of Breast Cancer \_\_\_\_\_

Surgical History: \_\_\_\_\_

Other Information: \_\_\_\_\_



Mammography Staff Use

Technologist Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_