|  |  |
| --- | --- |
| **BREAST IMAGING REQUEST FORM**  **Call (540) 332-4486**  **FAX Screening Orders to (540) 332-4490 FAX Biopsy Orders to (540)332-5387**  **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**: [ ] Breast Imaging (Outpatient Pavilion) [ ] Staunton [ ] Stuarts Draft **Patient Name**: **Date of Birth**:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| * **Screening Mammogram w/ Tomosynthesis** | **[** | **] Bilateral** | **[** | **] Right** | **[** | **] Left** |
| * **Diagnostic Mammogram w/ Tomosynthesis** | **[** | **] 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:

*Reviewed 5/9/2025, Policy Manager*