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

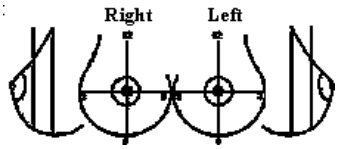
Patient Name:_____ **Date of Birth**: _____

• **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 _____

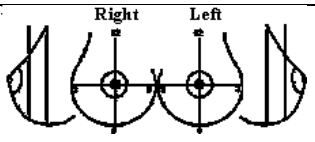
Family/Personal History of Breast Cancer _____

Surgical History: _____

_____

Other Information: _____

_____



Mammography Staff Use

Technologist Signature:_____**Date/Time:** _____

Reviewed 2/23/2026, Policy Manager