Breast Biopsy Referral

Check In at:
The VRI Breast Center
3186 Village Dr., Ste 200
Located on the 2nd floor
Fayetteville, NC 28304

Valley Radiology

Valley Radiology, PA
Phone: (910) 486-5700
Fax: (910) 486-5950
STAT REFERRAL_____

Please complete all sections to avoid scheduling delays.

Patient Information

Patient Name: _____
Date of Birth: _____
Phone Number: _____
Secondary Phone (optional): _____
Email (optional): _____
Insurance Name:_____
Member ID: _____

Referring Provider Information

Referring Provider:_____
STAT Call Back Number: _____
Practice / Facility: _____
Phone: _____
Fax: _____
Address: _____
_____

Fax completed form and relevant imaging reports to: (910) 486-5950 Phone for scheduling questions: (910) 486-5700

Procedure Requested (check all that apply)

ICD 10 / Diagnosis / Indication:_____

□ Ultrasound-Guided Breast Biopsy	□ Left	□ Right	□ Both	□ Multi-Site
□ Stereotactic Breast Biopsy	□ Left	□ Right	□ Both	□ Multi-Site
□ Axillary Lymph Node Biopsy	□ Left	□ Right	□ Both	□ Multi-Site
□ Breast Cyst Aspiration w/core if necessary □ Diagnostic □ Therapeutic	□ Left	□ Right	□ Both	□ Multi-Site
□ Other_____	□ Left	□ Right	□ Both	□ Multi-Site

Relevant Clinical History / Indication (required): Include symptoms, physical exam findings, prior biopsy history, or risk factors supporting medical necessity. Imaging Information (if available)

_____

_____

Prior Imaging Performed At: _____
Date of Most Recent Imaging: _____
BI-RADS (if known): □ 3 □ 4 □ 5 □ Unknown

Provider Signature_____**Date:**_____

Results & Patient Communication:
- **Imaging reports and pathology results will be routed to the referring provider.**
- **The referring provider is responsible for communicating results and follow-up recommendations to the patient.**

Valley Radiology, PA will issue imaging-pathology correlation and management recommendations in accordance with ACR and MQSA standards.