Breast Imaging Requisition – Mammogram and Breast Ultrasound

Breast Imaging Requisition
Phone: 519-941-2410 ext. **2842**
Fax: 519-941-7726
100 Rolling Hills Drive, Orangeville ON L9W 4X9

PATIENT NAME	
DATE OF BIRTH	
PHONE # [HOME/CELL]	
HEALTH CARD #	
HOME ADDRESS	
EMAIL ADDRESS	

OBSP SCREENING for average risk Age 40-74
[with NO Symptoms or Personal History of Breast Cancer]
Patients can CALL OBSP Bookings (519) 941-2410 ext. 2842

HIGH-RISK OBSP SCREENING for Age 30-69
Please Download CancerCareOntario HR OBSP FORM
FAX COMPLETED HR OBSP FORM to 519-941-7726

MAMMOGRAM

☐ **ROUTINE SCREENING** ☐ **BREAST IMPLANTS**

☐ **SYMPTOMATIC MAMMOGRAM**
- ☐ NEW MASS *
- ☐ NEW SYMPTOMS*
- ☐ FOCAL TARGETED PAIN
- ☐ OTHER:

≥ 30 Yrs of age:
* Order Symptomatic Mammogram + Targeted Breast Ultrasound

☐ **BIRADS 3 FOLLOW-UP MAMMOGRAM** ☐ **Right** ☐ **Left**

BREAST ULTRASOUND

☐ **TARGETED BREAST ULTRASOUND** ☐ **Right** ☐ **Left**
[Must Specify on diagram above Area of Concern]

☐ **BIRADS 3 FOLLOW-UP ULTRASOUND** ☐ **Right** ☐ **Left**

NOTE: Breast Ultrasound is not appropriate for Screening purposes in Average Risk Population. Physician MUST identify the AREA OF CONCERN

Relevant Clinical Information/Reason for Exam:

RIGHT LEFT

[Indicate Area of Concern on diagram]

BREAST INTERVENTIONAL PROCEDURES

☐ **ULTRASOUND BREAST BIOPSY**	☐ Right	☐ Left
☐ **STEREOTACTIC BREAST BIOPSY**	☐ Right	☐ Left
☐ **ULTRASOUND LOCALIZATION**	☐ Right	☐ Left
☐ **STEREOTACTIC LOCALIZATION**	☐ Right	☐ Left

☐ **BIOPSY REQUEST FROM OUTSIDE IMAGING**
MUST INCLUDE All previous breast imaging reports with this referral
Radiologist's consultation on recent imaging will be made prior to Patient Booking

RELEVANT CLINCIAL HISTORY

Patient on Blood Thinners ☐ YES ☐ NO
If YES, please specify:
History of Breast Cancer ☐ YES ☐ NO
Previous Breast Surgery ☐ YES ☐ NO
Previous Breast Biopsy ☐ YES ☐ NO

Prior Breast Imaging (Mammo, Ultrasound & MRI)
Location:
Date of Last exam: (DD/MM/YYYY)

☐ By **NOT** checking this box I, as referring physician, authorize and consent, this patient to receive any additional breast imaging and interventional procedures as indicated by the radiologist through the Breast DAP, to resolve this diagnostic request.

Referring Physician Name:
Referring Physician's Signature:
CPSO #:

Copies To:
Office Phone Number:
Date: (DD/MM/YYYY)

INCOMPLETE or UNSIGNED requisition will be RETURNED, Resulting in DELAY of BOOKING

For Patient Preparation and Information, please visit us online at Headwatershealth.ca
Reminder: Patient must bring your Ontario Health Card and please arrive 30 minutes prior to exam time.