

# DIAGNOSTIC IMAGING: BREAST IMAGING



Ordering Physician Name  
(Please Print)

Ordering Physician Signature

Copy to:

Pregnant: Yes No

LMP:

## OUTPATIENT SERVICES

Name:

DOB:

HCN:

Phone #:

Address:

**Routine**

**Urgent**

**PLEASE BRING THIS REQUISITION AND YOUR HEALTHCARD**

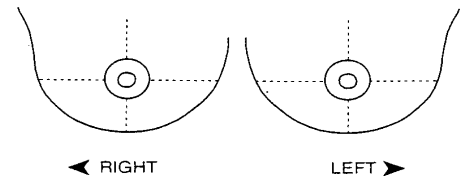
**Please call the Diagnostic Booking Office T: 613-969-7400 ext 2494 or 2949  
OR Fax Completed Requisition F: 613-969-5561  
If calling from the Bancroft area call 613-332-2825 ext. 2494 or ext. 2949**

PLEASE CHOOSE ONE OF THE FOLLOWING:

1. ROUTINE **NON OBSP** SCREENING MAMMOGRAM (please have the **PATIENT CALL** the booking office for appointment)
2. SURVEILLANCE SCREENING MAMMOGRAM (previous cancer)
3. RADIOLOGIST RECOMMENDED IMAGING FOLLOW UP (Please indicate below:  
MAMMO RECOMMENDED  
**OR**  
ULTRASOUND RECOMMENDED FOLLOW UP DUE DATE: \_\_\_\_\_)
4. ABNORMAL CLINICAL BREAST EXAM (new lump, thickening, nipple discharge, etc)
5. ULTRASOUND GUIDED BREAST BIOPSY

<b>Previous Mammogram</b>	Yes	No	<b>Where</b>	<b>When</b>
<b>Previous Breast Ultrasound</b>	Yes	No	<b>Where</b>	<b>When</b>

Clinical History:



**All abnormal QHC mammograms will be referred by the consulting radiologist to the QHC/OBSP Breast Assessment Program**

DEPARTMENTAL USE ONLY:	NOTES:
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Date Requisition Received: Booking Date: Site :    BGH    TMH    PEC                      Time:	
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**Patient Instructions**

Do not use deodorant, talcum powder or cream on your breasts or underarms on the day of your appointment. Dress comfortably in a two piece outfit since you will be asked to undress above the waist for the test. Please do not be alarmed if additional films or ultrasound is necessary at the time of your visit, or you are called back for additional views or imaging.