Reset

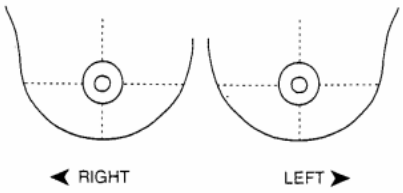
DIAGNOSTIC IMAGING – BREAST IMAGING

MAMMO

QHC Quinte Health Care	MD Name:	Patient Name:
	Signature:	DOB:
	MD Phone:	HCN:
	Date: (d/m/y)	Home Phone:
FAX ALL REQUISITIONS TO: 613-969-5561	Copies to:	Cell Phone
	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

CLINICAL INDICATION:



PLEASE CHOOSE ONE OF THE FOLLOWING:

- ☐ Routine **NON-OBSP** screening mammogram
- ☐ Surveillance screening mammogram (previous cancer)
- ☐ Radiologist recommended imaging follow up (specify below)
  - ☐ Mammo recommended ☐ Ultrasound recommended
  - Follow up due date: _____
- ☐ Abnormal clinical breast exam (new lump, thickening, nipple discharge, etc)
- ☐ Ultrasound guided breast biopsy

Previous Mammo Y ☐ N ☐	Where:	When:
Previous Breast US Y ☐ N ☐	Where:	When:

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

DEPARTMENT USE ONLY:

Mammogram:	Screen	Diagnostic	Bilateral	Rt	Lt
Views:	TL CC MLO	Coned CC	Coned MLO	Mag CC/TL	
Breast US:	Screen	Targeted	Bilateral	Rt	Lt
Axillary US:	Bilateral	Rt Lt			

Appointment Date & Time:_____

PLEASE ENSURE REQUISITION IS COMPLETE. FAX REQUISITION TO 613-969-5561

Rev:2019