



HOTEL DIEU HOSPITAL
 166 BROCK STREET
 KINGSTON, ON K7L 5G2
(613) 544-3400 ext 3434
FAX: 613-544-2504

**BREAST ASSESSMENT PROGRAM
 IMAGING REQUISITION**

Appointment Date/Time: _____

OBSPK#: _____

Right Left

<input type="checkbox"/>	<input type="checkbox"/>	Routine Screening Mammogram
<input type="checkbox"/>	<input type="checkbox"/>	Mammogram (for specific clinical abnormality)
<input type="checkbox"/>	<input type="checkbox"/>	Cone compression
<input type="checkbox"/>	<input type="checkbox"/>	Cone magnification
<input type="checkbox"/>	<input type="checkbox"/>	Ultrasound
<input type="checkbox"/>	<input type="checkbox"/>	Ductogram

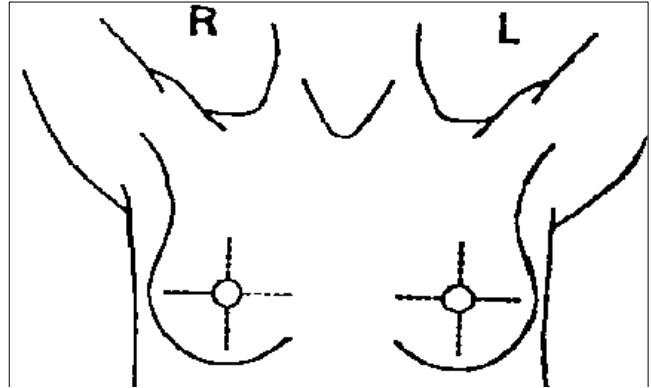
RADIOLOGY CONSULT FOR:

<input type="checkbox"/>	<input type="checkbox"/>	Image Guided Core Biopsy
<input type="checkbox"/>	<input type="checkbox"/>	Fine Needle Aspiration
<input type="checkbox"/>	<input type="checkbox"/>	Needle Localization/Specimen Radiograph
<input type="checkbox"/>	<input type="checkbox"/>	Sentinel Node Biopsy

CR#:
 Name:
 Date of Birth
 Address:

 Postal Code:
 Home Tel#:
 Business Tel #:
 HN #:
 Family Physician:

Please indicate location of abnormality below



Abnormality Detected by:

- Clinical Breast Exam
- Mammogram

Previous Mammogram completed at: _____ **Date:** _____

Clinical Information and History:

Is the patient taking blood thinners? Yes No **Please instruct your patient appropriately.**

Breast Implant? Right Left

Details of Current Findings:

I also agree that any of the following be arranged at the discretion of the Radiologist: core biopsy, fine needle aspiration or other breast imaging as required.

Signature: _____ **for** _____

Physician name (print): _____

Date: _____

Send a copy of report to:

