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

CR#:
Name:
Date of Birth
Address:

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

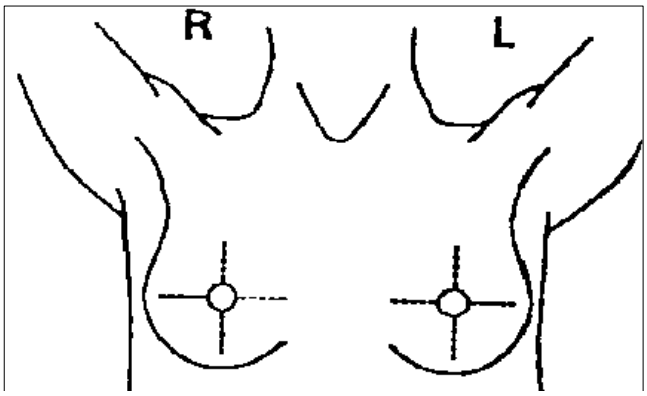
BREAST ASSESSMENT PROGRAM
IMAGING REQUISITION

Appointment Date/Time:_____

OBSPK#:_____

Right	Left	
☐	☐	**Routine Screening Mammogram**
☐	☐	**Mammogram** (for specific clinical abnormality)
☐	☐	**Cone compression**
☐	☐	**Cone magnification**
☐	☐	**Ultrasound**
☐	☐	**Ductogram**

Please indicate location of abnormality below



RADIOLOGY CONSULT FOR:

☐	☐	**Image Guided Core Biopsy**
☐	☐	**Fine Needle Aspiration**
☐	☐	**Needle Localization/Specimen Radiograph**
☐	☐	**Sentinel Node Biopsy**

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:

_____

_____

_____