HALIBURTON HIGHLANDS HEALTH SERVICES

BREAST IMAGING REQUISITION

T: (705) 457-1392 · F: (705) 457-1071

*ALL fields in **bold** must be completed to process request.*

Last Name (Legal)	**First Name (Legal)**
DOB: dd-mm-yyyy **Age:**	**Phone Number**
Address	**Health Card#**

ANY MOBILITY OR COMMUNICATION ISSUES? ☐ Yes ☐ No Please specify: ______________________

Screening (Asymptomatic) – Routine

Clinical History:

Prior Mammograms:

☐ Yes ☐ No

Date(s): __________________________

Location: _________________________

Failure to provide previous breast imaging will result in delay of patient appointment

Breast Implants:

☐ Yes ☐ No

Date: ____________________________

Type: ☐ saline ☐ silicone ☐ other

Description/Comments:

R L

Previous Biopsy/Surgery:

☐ Yes ☐ No

Date: _____________________________

Outcome: __________________________

Personal History of Breast Cancer:

☐ Yes ☐ No

Year of Dx: _________________________

☐ lumpectomy ☐ mastectomy

Family History of Breast Cancer:

☐ Yes ☐ No

Whom: ___________________________

Patient must not wear any deodorant or talcum powder on the day of their examination.

Ordering Provider Name (Print): ____________________________ **Order Date:** __________________________

Ordering Provider Signature: ______________________________ **OHIP Billing #:** _________________________