



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

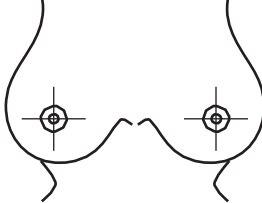
Previous Biopsy/Surgery:
 Yes No
 Date: _____
 Outcome: _____

Personal History of Breast Cancer:
 Yes No
 Year of Dx: _____
 lumpectomy mastectomy

Family History of Breast Cancer:
 Yes No
 Whom: _____

Description/Comments:

R L



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 #: _____