HALIBURTON HIGHLANDS HEALTH SERVICES

BREAST IMAGING REQUISITION

T: (705) 457-1392 ext 2381 · F: (705) 457-1071

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

***Please Note** - Generalized or cyclic breast pain can be treated on clinical grounds. Any nipple discharge that is bilateral, from multiple ducts and/ or yellowish, green or milky is considered physiologic and is not suitable for referral.*

☐ Routine Screening Mammogram

☐ Diagnostic (Symptomatic) BAC

☐ Breast Ultrasound

PATIENT DEMOGRAPHICS

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

ANY MOBILITY OR COMMUNICATION ISSUES? Specify:_____ ☐ Yes ☐ No

Screening (Asymptomatic) - Routine

PRIOR MAMMOGRAMS: ☐ Yes ☐ No

Date(s):

Location:

CLINICAL HISTORY:

- Breast Implants: ☐ Yes ☐ No

Date:

Type: ☐ saline ☐ silicone ☐ other

- Previous Biopsy/Surgery: ☐ Yes ☐ No

Date:

Outcome:

- Personal History of Breast Cancer: ☐ Yes ☐ No

☐ lumpectomy ☐ mastectomy

Year of Dx:

- Family History of Breast Cancer: ☐ Yes ☐ No

Whom:

Diagnostic (Symptomatic) - BAC

1. Palpable Abnormality/Lump: ☐ R ☐ L ☐ Both

   Location: Size:

   ☐ firm ☐ mobile

2. Breast Pain/Other: ☐ R ☐ L ☐ Both

   ☐ cylic ☐ non-cyclic

   ☐ focal ☐ diffuse

3. Discharge: ☐ R ☐ L ☐ Both

   Colour:

   ☐ single duct ☐ multiple duct

   ☐ one time ☐ multiple times

4. Skin Change: ☐ R ☐ L ☐ Both

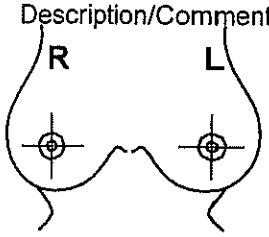
   thickening: ☐ Yes ☐ No

   redness/swelling/rash: ☐ Yes ☐ No

   dimpling/puckering: ☐ Yes ☐ No

   nipple retraction/inversion ☐ Yes ☐ No

Description/Comments:



RADIOLOGIST USE ONLY

Priority 1 2 3 4

Mammo	*US*	*Booking*
☐ Bilateral	☐ Bilateral	☐ Screening
☐ Unilateral	☐ Unilateral	☐ BAC
☐ None	☐ None	

Physician Name (Print): _____

Physician Signature: _____

Order Date: _____

Billing #: _____