 RMH BREAST ASSESSMENT CLINIC - BAC

**BREAST IMAGING REQUISITION**

T: (705) 328-6175 · F: (705) 328-6188 www.rmh.org

*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.*

**PATIENT DEMOGRAPHICS**

🞏 Routine Screening Mammogram

🞏 Diagnostic (Symptomatic) BAC

🞏 Breast Ultrasound

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

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|  |  |
| --- | --- |
| **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   1. Breast Pain/Other:  R  L  Both   cylic  non-cyclic  focal  diffuse   1. Discharge:  R  L  Both   Colour:  single duct  multiple duct  one time  multiple times   1. 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

**R** **L**

**Physician Name (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Order Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_