RMH BREAST ASSESSMENT CENTRE

BREAST IMAGING REQUISITION

T: (705) 328-6175 · F: (705) 328-6188

ROSS MEMORIAL HOSPITAL
Kawartha Lakes

PATIENT DEMOGRAPHICS

Name: _____

DOB: _____

Address: _____

Phone: #: _____

HCN: _____

OFFICE USE ONLY
Appt. Date/Time

Routine Screening Mammographic Examination ☐
Evaluation at Breast Assessment Centre ☐

PRIOR MAMMOGRAMS:

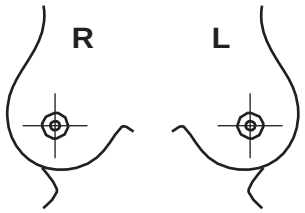
Yes ☐ Date(s): Location:
No ☐

CLINICAL HISTORY:

Personal history of breast cancer: Yes ☐ No ☐ Year of Dx _____
Breast implants: Yes ☐ No ☐

PALPABLE ABNORMALITY

Size_____Location



BREAST PAIN

Breast: L ☐ R ☐ Both ☐
Cyclic ☐ Non-cyclic ☐
Focal ☐ Diffuse ☐

Generalized or cyclic breast pain can be treated on clinical grounds.

NIPPLE DISCHARGE

Breast L ☐ R ☐ Both ☐
Unilateral Y ☐ N ☐ Single Duct Y ☐ N ☐

Any nipple discharge that is bilateral, from multiple ducts and/ or yellowish, green or milky is considered physiologic and is not suitable for referral.

Referring Physician

Name: _____

Phone #: _____

Billing #: _____

Signature_____Order Date: _____

RADIOLOGIST USE ONLY

Priority: 1 2 3 4