 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#** |

*.*

**ANY MOBILITY OR COMMUNICATION ISSUES?** Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| **Screening (Asymptomatic) - Routine**PRIOR MAMMOGRAMS: [ ]  Yes [ ]  NoDate(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 [ ]  mastectomyYear of Dx:* Family History of Breast Cancer:[ ]  Yes [ ]  No

Whom: | **Diagnostic (Symptomatic) - BAC**1. Palpable Abnormality/Lump: [ ]  R [ ]  L [ ]  Both

Location: Size:[ ]  firm [ ]  mobile1. Breast Pain/Other: [ ]  R [ ]  L [ ]  Both

[ ]  cylic [ ]  non-cyclic [ ]  focal [ ]  diffuse1. Discharge: [ ]  R [ ]  L [ ]  Both

Colour:[ ]  single duct [ ]  multiple duct[ ]  one time [ ]  multiple times1. Skin Change: [ ]  R [ ]  L [ ]  Both

thickening: [ ]  Yes [ ]  Noredness/swelling/rash: [ ]  Yes [ ]  Nodimpling/puckering: [ ]  Yes [ ]  Nonipple 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 #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_