fraserhealth

BREAST IMAGING REQUISITION

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Hospital Site: _____

Appt. Date: _____ **Time:** _____

Interpreter needed? ☐ Yes ☐ No

Language: _____

Please arrive 20 minutes early for registration/parking.

☐ **BREAST ULTRASOUND**
☐ **MAMMOGRAPHY**
☐ **RT** ☐ **LT** ☐ **BILATERAL**

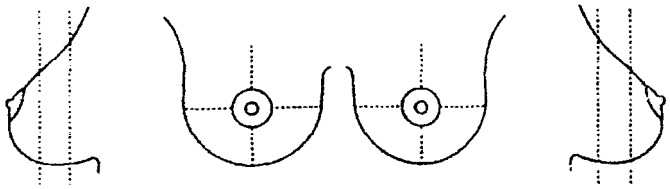
Date Ordered	Date Required	Date Received
Sex M F	Surname	First Name
Address		
City		Home Phone
Date of Birth (dd/mm/yy)		Work Phone
Medical Plan Number		WCB / ICBC Claim Number

☐ MSP ☐ WCB ☐ ICBC ☐ PATIENT ☐ OTHER _____

Proceed to further Imaging if indicated (Mammography or Ultrasound/MRI)
☐ **Arrange needle biopsy if indicated and feasible**

PLEASE MARK AREA(S) OF CONCERN:

Right Left



PRESENT COMPLAINT:

☐ Lump
☐ Thickening
☐ Previous breast cancer
☐ Nipple discharge
☐ Localized pain / tenderness
☐ Abnormal Screening Mammogram
☐ Follow-up of previous findings (specify) _____
_____
_____
☐ Dimpling, contour deformity
☐ Breast prosthesis (implants)
☐ Other (specify) _____
_____

HISTORY:

Previous Mammograms: ☐ Yes ☐ No
All Locations: _____ Date: _____
_____ Date: _____
Previous Ultrasound: ☐ Yes ☐ No
All Locations: _____ Date: _____
_____ Date: _____
Menopause / LMP: _____
Hormone Therapy: ☐ Yes ☐ No
Family history of breast cancer: ☐ Yes ☐ No
Who/Age: _____
Previous biopsies / surgeries: _____
_____
_____

TECHNOLOGIST USE ONLY

Notes:

# of Exposures: _____ Tech Initials: _____

Stores # 316459

• INCOMPLETE REQUESTS WILL BE RETURNED •

Requesting Physician: _____ Physician Signature: _____
(Please Print)

Additional Copies of Report: _____ Billing #: _____ Phone: _____ Fax: _____