Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
*Partnering to keep healthcare close to home.*

# BREAST IMAGING REQUISITION

Tillsonburg District Memorial Hospital (TDMH)
TDMH Scheduling/Bookings Contact:
Phone: 519-842-6335 Fax: 519-842-4299

## Referring Physician or Other Authorized Health Care Provider

Name (Please Print): ____________________________

Phone:________________Fax:____________________

Provider Billing #:___________________________

Provider Signature: __________________________

Copy to:________________________________

**By signing this requisition you are providing authorization for your patient to receive additional imaging (Mammography, Ultrasound, and other procedures) as deemed necessary by the responsible Radiologist to resolve this diagnostic request.

## Patient Information:

Name (Last, First): ______________________________________

Date of Birth (DOB) : (YYYY/MM/DD) _________________________

Personal Identification Number (PIN): _________________________

Address: _______________________________________________

Phone Number (Home): ____________________________

(Other): ____________________________

Health Card Number:__________________ Version Code: _______

**Does this patient have?**

**Previous Breast Imaging:** ☐ No ☐ Yes

**When:** ________________________________________

**Where:** ________________________________________

**Previous Breast Cancer:** ☐No ☐ Yes

**Mastectomy:** ☐ Right ☐ Left

**Implants:** ☐ No ☐ Yes

**Special needs or impairments, specify:________________________**

_______________________________________________________

**Patients 40-74 with no history of breast cancer or current breast concerns will be part of the Ontario Breast Screening Program.

## Examination (s) Requested:

### MAMMOGRAM

Routine Screening Mammogram (Asymptomatic)
OBSP Screening Mammogram (Asymptomatic)
Diagnostic Mammogram (Symptomatic)

Right (RT) Left (LT)

### ULTRASOUND (US)

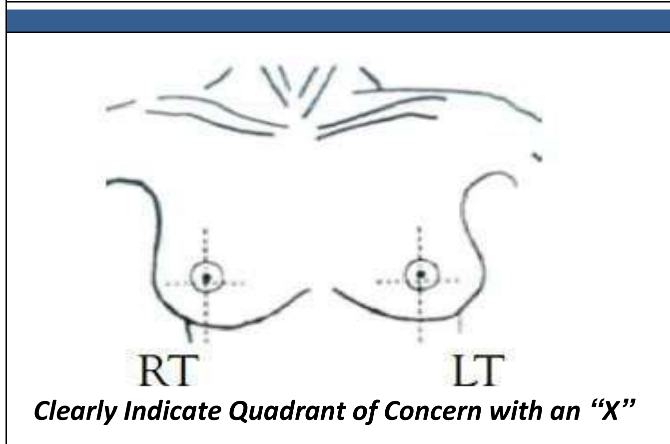
☐ RT Breast ☐ RT Axilla
☐ LT Breast ☐ LT Axilla
☐ Bilateral Breast
☐ Bilateral Axilla

### US Guided Procedures

☐ Biopsy
RT LT Bilateral

☐ Aspiration
RT LT Bilateral

Localization
RT LT Bilateral




***Clearly Indicate Quadrant of Concern with an "X"***

1) Pain? No
Yes , specify area ____________________
f focal or diffuse

2) Lump felt?
By patient
By Physician, specify location ________________

3) Other, please specify:

_______________________________________________

4) If the patient is over 70 yrs old please include Creatinine within 6 months in case a Contrast mammogram is required: __________
Date: (YYYY/MM/DD) ____________________

## CLINICAL HISTORY:

**UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RETURNED AND APPOINTMENTS WILL NOT BE BOOKED UNTIL A SIGNED AND COMPLETED REQUISITION IS RECEIVED.**