Central Health

Medical Imaging

MAMMOGRAPHY

REQUEST FOR EXAM & CONSULTATION

Date Received by MI Dept.

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED

1 **EXAM REQUIRED:** _____

2 **PATIENT INFORMATION:**

Status: ☐ OUTPATIENT ☐ INPATIENT

☐ MCP ☐ WHSCC ☐ NR ☐ DVA ☐ DND

☐ OTHER

Name: _____

Address: _____

_____

City: _____ Postal Code: _____

DOB: _____ Sex: _____

Phone: _____ (Work): _____

MCP #: _____ Chart #:_____

3 **Please identify urgency:**

Priority Circle appropriate number:	**Specific Date?** D/M/Y
1 Urgent (0-14 days)	
2 Non-Urgent (0-30 days)	
3 Follow-up	

4 **To be completed by Medical Imaging:**

Appointment date: _____

Patient Notified: ☐ Phone ☐ Message ☐ Mail

Patient preparation instructions: ☐ Yes ☐ No

Exam protocol:

5 **CLINICAL INFORMATION:**

Does patient have any contact precautions? ☐ Yes ☐ No

Is patient breastfeeding? ☐ Yes ☐ No

Does patient have any allergies? ☐ Yes ☐ No

Patient's LMP : _____

Describe any allergies and reactions: _____

Date of previous mammogram: _____

List any medications the patient is taking: _____

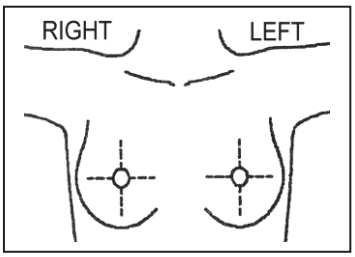
Does patient have mobility issues? ☐ Yes ☐ No _____

6 **CLINICAL INDICATIONS FOR EXAM** (including previous relevant studies):

_____

_____

_____



Initial screening (bilateral): ☐ Yes ☐ No Lump/Thickening/Nodularity: ☐ Right ☐ Left

Axillary adenop ☐ Right ☐ Left Inflammation/Skin changes: ☐ Right ☐ Left

Nipple discharge/retraction: ☐ Right ☐ Left Contralateral surveillance: ☐ Right ☐ Left

Pain/Discomfort: ☐ Right ☐ Left Other: _____

CLINICAL DIAGNOSIS: _____

_____

7

Requesting Physician (PRINT & SIGN): _____

Date: _____ **Phone Number**_____

Report to be sent to Dr. (PLEASE PRINT): _____

Adapted from Eastern Health, January 2008

MEDICAL IMAGING - BREAST HISTORY

TO BE COMPLETED BY TECHNOLOGIST/PATIENT

Patient Name:	**Age:**	**Date:**

Family History Breast/Ovarian Cancer

1st Degree: Mother ☐ Daughter ☐ Sister ☐

2nd Degree: Maternal Aunt ☐ Paternal Aunt ☐ Maternal Grandmother ☐ Paternal Grandmother ☐

Date of Last Menstrual Period: _____ **Pregnant Now**: ☐ Yes ☐ No

Menopause: ☐ Yes ☐ No **Hysterectomy**: ☐ Yes* ☐ No *(If yes, when:_____)

Number of Pregnancies: _____ **Deliveries**: _____

Nursed: ☐ Yes* ☐ No *(If yes, how many: _____) **Age at Birth of First Child**: _____

Contraceptive Pill: ☐ Yes ☐ No

Hormone: ☐ Yes* ☐ No *(If yes, when: _____, what:_____)

Previous Breast Surgery: ☐ Yes* ☐ No *(If yes, when: _____) Right ☐ Left ☐

Diagnosis: _____

Needle Puncture in Last Month: Right ☐ Left ☐

Radiation Treatment: ☐ Yes* ☐ No *(If yes, when: _____)

Previous Mammogram: ☐ Yes* ☐ No *(If yes, when: _____, where: _____)

Previous Ultrasound: ☐ Yes* ☐ No * (If yes, when: _____, where _____)

Pain, Tenderness, Other Sensation: Right ☐ Left ☐ How Long: _____

Palpable Lump: Right ☐ Left ☐ How Long: _____

Skin Nodule (Warts, Moles, Etc): Right ☐ Left ☐

Discharge: Right ☐ Left ☐ Color: _____

Skin Redness, Enduration: Right ☐ Left ☐ How Long: _____

Trauma: Right ☐ Left ☐ When: _____

NOTES:

_____

_____

_____

_____

_____