

DIAGNOSTIC BREAST IMAGING REQUISITION

Depending on wait times, patients may be scheduled at any of our hospital sites in the Niagara region

PHONE: 905-378-4647

☐ St. Catharines Site

Ext: 46345 Fax: 905-323-7592

☐ Niagara Falls Site ☐ Fort Erie Site
Ext: 54952 Fax: 905-358-4956

☐ Welland Site ☐ Port Colborne Site
Ext: 33294 Fax: 905-732-4654

☐ ED REQUEST

☐ NEXT AVAILABLE

☐ WITHIN 2-3 WEEKS

☐ ROUTINE

APPOINTMENT DATE/TIME/SITE: _____

DD / MM / YYYY

HH : MM

SITE

PATIENT INFORMATION (PLEASE PRINT)

ORDERING PROVIDER INFORMATION

PATIENTS LAST NAME		PATIENTS FIRST NAME		ORDERING PROVIDER NAME		FAMILY PROVIDER (*Required*)	
ADDRESS		CITY		PHONE NUMBER		URGENT RESULTS CONTACT #	
MOBILE PHONE (PREFERRED CONTACT METHOD)	HOME PHONE	PROVINCE	POSTAL CODE	SIGNATURE		FAX NUMBER	
OHCN/OHIP#	VERSION CODE	DATE OF BIRTH (DD/MM/YYYY)	GENDER	<input type="checkbox"/> WSIB CLAIM #:			

CAN THE PATIENT COME IN ON SHORT NOTICE? ☐ YES ☐ NO DOES THE PATIENT HAVE ANY ACCESSIBILITY ISSUES? ☐ YES ☐ NO IF YES, SPECIFY:

CAN WE CONTACT YOU BY EMAIL? ☐ YES ☐ NO IF YES, PLEASE PROVIDE YOUR EMAIL ADDRESS:

IT IS THE REFERRING PROVIDERS RESPONSIBILITY TO NOTIFY THE PATIENT OF APPOINTMENT DETAILS

CLINICAL INFORMATION (INCLUDE SPECIFIC QUESTIONS TO BE ANSWERED)

RIGHT LEFT



MAMMOGRAPHY

OTHER PROCEDURES

MAMMO ☐ RIGHT ☐ LEFT
STEREO BIOPSY ☐ RIGHT ☐ LEFT
DUCTOGRAM ☐ RIGHT ☐ LEFT

NUCLEAR MEDICINE SEED INSERTION ☐ RIGHT ☐ LEFT
CLIP INSERTION ☐ RIGHT ☐ LEFT

ULTRASOUND

OBSP PROGRAM

ULTRASOUND ☐ RIGHT ☐ LEFT
ULTRASOUND BIOPSY ☐ RIGHT ☐ LEFT
AXILLARY LN US ☐ RIGHT ☐ LEFT
AXILLARY LN BIOPSY ☐ RIGHT ☐ LEFT

If your patient/client is:

- between the ages of 40-74
- does not have a history of breast cancer
- has no current breast issues

please call 905-378-4647 x46349 to enroll in the OBSP program. This requisition will not be used to book an OBSP screening. For assessment information, please visit <https://www.mycanceriq.ca/>

PATIENT HISTORY

HAS THE PATIENT HAD A PREVIOUS MAMMOGRAM DONE? ☐ YES ☐ NO

IF YES, DATE: _____ LOCATION IT WAS DONE: _____

HAS THE PATIENT HAD A PREVIOUS ULTRASOUND OF THE BREAST DONE? ☐ YES ☐ NO

IF YES, DATE: _____ LOCATION IT WAS DONE: _____

HAS THE PATIENT HAD A PREVIOUS MRI OF THE BREAST DONE? ☐ YES ☐ NO

IF YES, DATE: _____ LOCATION IT WAS DONE: _____

DOES THE PATIENT HAVE BREAST IMPLANTS? ☐ YES ☐ NO IF YES, SPECIFY: ☐ RIGHT ☐ LEFT ☐ BILATERAL

IS THE PATIENT EXPERIENCING ANY NIPPLE DISCHARGE?

☐ YES ☐ NO COMMENT: _____

DOES THE PATIENT HAVE AN UPCOMING SURGICAL DATE? ☐ YES ☐ NO DATE (DD/MM/YYYY): _____

DID THE PATIENT HAVE PREVIOUS BREAST SURGERY? ☐ YES ☐ NO DATE (DD/MM/YYYY): _____

DOES THE PATIENT HAVE A HISTORY OF CANCER? ☐ YES ☐ NO IF YES, WHAT KIND? _____

IF THE PATIENT HAS HAD PREVIOUS BREAST IMAGING PERFORMED OUTSIDE OF NIAGARA HEALTH, THE PATIENT MUST BRING A DIGITAL COPY ON A CD OR THROUGH POCKET HEALTH

PLEASE NOTE: INCOMPLETE REQUISITIONS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT