niagarahealth
Extraordinary Caring. Every Person. Every Time.

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)

PATIENTS LAST NAME		PATIENTS FIRST NAME	
ADDRESS		CITY	
MOBILE PHONE (PREFERRED CONTACT METHOD)	HOME PHONE	PROVINCE	POSTAL CODE
OHCN/OHIP#	VERSION CODE	DATE OF BIRTH (DD/MM/YYYY)	

ORDERING PROVIDER INFORMATION

ORDERING PROVIDER NAME	FAMILY PROVIDER (*Required*)
PHONE NUMBER	URGENT RESULTS CONTACT #
SIGNATURE	FAX NUMBER
☐ WSIB CLAIM #:	

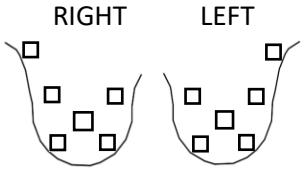
CAN THE PATIENT COME IN ON SHORT NOTICE? ☐ YES ☐ NO

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)



MAMMOGRAPHY

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

OTHER PROCEDURES

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

ULTRASOUND

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

OBSP PROGRAM

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:** ☐ LEFT ☐ RIGHT ☐ 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

Version 2: OCT2025