REQUEST FOR BREAST IMAGING

HUMBER RIVER HOSPITAL

Breast Health Centre
Wilson Avenue Site
1235 Wilson Avenue, 2nd Floor
Toronto, ON M3M 0B2
TEL. (416) 242-1000 EXT 63603
FAX (416) 242-1055

Health Card No. _____

Last Name _____

First Name _____ ❑ M ❑ F

Date of Birth (d/m/y) _____

Address _____

_____

Phone _____

Appointment Date _____ **Appointment Time** _____

Medical Imaging Examinations Requested

Digital Mammogram	❑ Right	❑ Left	❑ Both	❑ Screening	❑ Implants
Breast Ultrasound	❑ Right	❑ Left	❑ Both		
Ductogram	❑ Right	❑ Left	❑ Both		
Ultrasound Breast Biopsy	❑ Right	❑ Left	❑ Both	❑ 1 Site	❑ 2+ Sites
Stereotactic Breast Biopsy	❑ Right	❑ Left	❑ Both	❑ 1 Site	❑ 2+ Sites
Sentinel Node Injection	❑ Right	❑ Left	❑ Both	❑ 1 Site	❑ 2+ Sites
Breast Needle Localization	❑ Right	❑ Left	❑ Both	❑ 1 Site	❑ 2+ Sites

❑ Densitometry (BMD) ❑ Densitometry (BMD) High Risk

❑ Other: _____

By signing this requisition, you are providing authorization to Humber River Hospital for your patient to receive additional breast imaging, procedures, and surgical referrals, as required, to resolve this diagnostic request.

ALL CDs and/or X-ray films and reports MUST be sent for this appointment.

Present Complaint

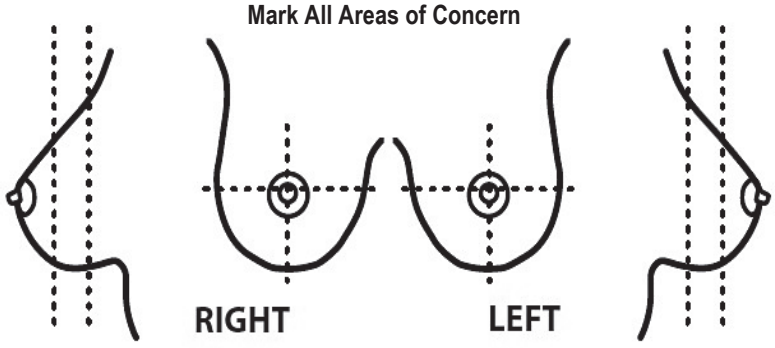
❑ Palpable Lump
❑ Localized Pain/Tenderness
❑ Nipple Discharge
❑ Previous History of Breast Cancer
❑ Abnormal Screening mammogram
❑ Dimpling and/or Contour Deformity
❑ Thickening
❑ Follow-up of Previous Findings

Specify: _____

❑ Other

Specify: _____

Mark All Areas of Concern



Physician's Name (Please PRINT) _____

Address _____

Phone _____ Fax _____

Physician's Signature × _____

INCOMPLETE, ILLEGIBLE, AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED

Screening breast ultrasound is not indicated in average risk population and requisition will be returned

Form # 100104, REV 2018_02

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