Request for Breast Imaging

Humber River Hospital
1235 Wilson Ave. **LEVEL 2 EAST**
Toronto, ON M3M 0B2
Phone 416-242-1000 Ext. 63601 ***Fax*** 416-242-1055

Appt. Date _____ **Appt. Time** _____

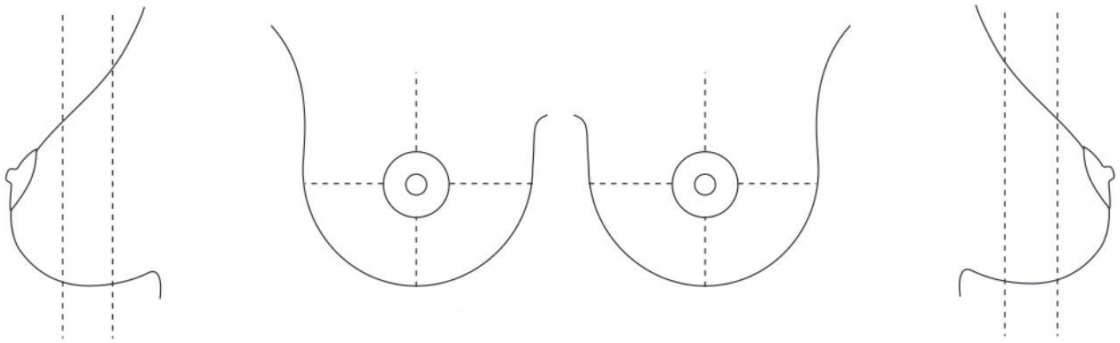
Patient Information

Name _____
OHIP # _____ VC _____
DOB (d/m/y) _____ Sex ☐ M ☐ F
Address _____
City _____ PC _____
Phone _____

Examination(s) Requested					
Digital Mammogram	☐ Right	☐ Left	☐ Both	☐ Screening	☐ Implants
Breast Ultrasound	☐ Right	☐ Left	☐ Both		
Ductogram	☐ Right	☐ Left	☐ Both		
Ultrasound Guided 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
Needle Localization	☐ Right	☐ Left	☐ Both	☐ 1 Site	☐ 2+ Sites
Radioactive Breast Seed Localization	☐ Right	☐ Left	☐ Both	☐ 1 Site	☐ 2+ Sites
Bone Mineral Density	☐ Baseline	☐ Low Risk	☐ High Risk		

Reason for Referral	***Clinical Information***
☐ Palpable Lump ☐ Localized Pain, Tenderness ☐ Nipple Discharge ☐ Previous History of Breast Cancer ☐ Abnormal Screening Mammogram ☐ Dimpling, Contour Deformity ☐ Thickening ☐ Follow-Up of Previous Findings ☐ Other _____	

Mark All Areas of Concern



R **L**

Requests for breast cancer screening ultrasound will be declined as this is not indicated in an average risk population. By signing this referral form, you give Humber River Hospital permission to deliver any additional testing as required in order to resolve this request. It is mandatory to bring all relevant images on CD and/or X-Ray film, as well as any related medical reports to this appointment.

Referring Doctor Information

Name (PRINT) _____
Address _____
City _____ PC _____
Phone _____ Fax _____
Signature _____
CPSO # _____ Billing # _____

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED

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Form # 100104, version (07-2019)