

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

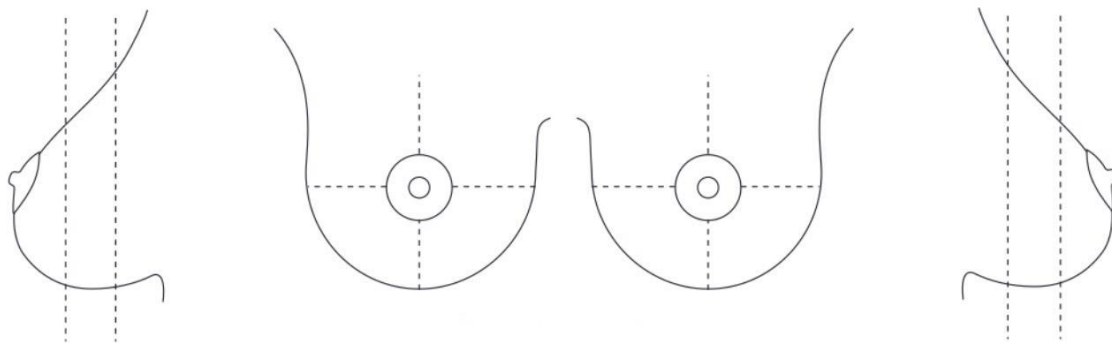


Patient Information	
Name	_____
OHIP #	_____ VC _____
DOB (d/m/y)	_____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address	_____
City	_____ PC _____
Phone	_____

Appt. Date _____ Appt. Time _____

Examination(s) Requested					
Digital Mammogram	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> Screening	<input type="checkbox"/> Implants
Breast Ultrasound	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both		
Ductogram	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both		
Ultrasound Guided Breast Biopsy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> 1 Site	<input type="checkbox"/> 2+ Sites
Stereotactic Breast Biopsy	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> 1 Site	<input type="checkbox"/> 2+ Sites
Sentinel Node Injection	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> 1 Site	<input type="checkbox"/> 2+ Sites
Needle Localization	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> 1 Site	<input type="checkbox"/> 2+ Sites
Radioactive Breast Seed Localization	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both	<input type="checkbox"/> 1 Site	<input type="checkbox"/> 2+ Sites
Bone Mineral Density	<input type="checkbox"/> Baseline	<input type="checkbox"/> Low Risk	<input type="checkbox"/> High Risk		
Reason for Referral			Clinical Information		
<input type="checkbox"/> Palpable Lump <input type="checkbox"/> Localized Pain, Tenderness <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Previous History of Breast Cancer <input type="checkbox"/> Abnormal Screening Mammogram <input type="checkbox"/> Dimpling, Contour Deformity <input type="checkbox"/> Thickening <input type="checkbox"/> Follow-Up of Previous Findings <input type="checkbox"/> Other _____					

Mark All Areas of Concern



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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

