HPHA BREAST CENTRE

BREAST IMAGING CONSULTATION

Name: _____

DOB: _____ ID Number: _____

Pt. Phone Number: _____ HC# _____

Clinical Information ***(mandatory)*** _____

_____

_____

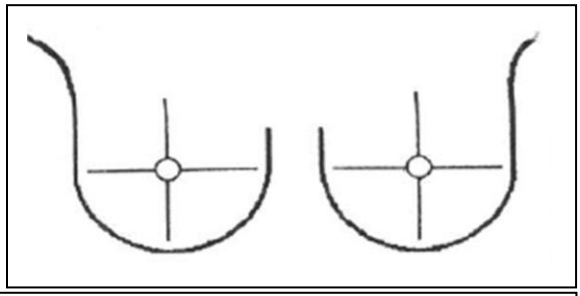
_____ MD NP PA _____ _____

Referring Clinician ***(please print)*** **Clinician's Signature** ***(mandatory)*** Date

CC Copies to: _____ Clinician's Phone# _____

Essential History

Previous Mammo	Yes ☐	No ☐	When: _____	Where: ☐ SGH	☐ other (specify) _____
Previous Breast US	Yes ☐	No ☐	When: _____	Where: ☐ SGH	☐ other (specify) _____
Previous Breast MRI	Yes ☐	No ☐	When: _____	Where: ☐ SGH	☐ other (specify) _____
Previous breast cancer	Yes ☐	No ☐	R or L When: _____		
Breast implants	Yes ☐	No ☐			
Patient pregnant	Yes ☐	No ☐			
Patient breast-feeding	Yes ☐	No ☐			



Reason for Investigation

☐Screen *(regular check-up/no problems)*

☐non OBSP ☐OBSP *(50 and over) **519-272- 8210 ext. 2339**

☐Surveillance/check-up for prior breast cancer

☐Follow-up evaluation of a prior Mammogram or US finding

☐New problem: Onset of symptoms?

☐ Breast lump	R ☐	L ☐	_____
☐ Thickening	R ☐	L ☐	_____
☐ Pain/tenderness	R ☐	L ☐	_____
☐ Nipple discharge	R ☐	L ☐	_____

Studies Requested

☐Mammogram ☐Bilateral R ☐ L ☐

☐Breast Ultrasound R ☐ L ☐

(US targets areas of clinical concern or Mammographic abnormality We do not offer "screening" US.)

☐Contrast Enhanced Mammography R ☐ L ☐

☐Tomosynthesis R ☐ L ☐

☐US-guided aspiration or biopsy R ☐ L ☐

☐Stereotactic core biopsy R ☐ L ☐

☐Pre-Op Needle Localization under: ☐ US ☐Mammo R ☐ L ☐

☐Lumpectomy ☐Mastectomy Date_____

☐Sentinel Node Localisation R ☐ L ☐

Contrast Enhanced Mammography ONLY

Weight: kg/lbs._____

☐ **Patient to bring a list of medications **

Y	N	
☐	☐	Allergy to Radiographic contrast

If YES to any of the following risk factors

please draw creatinine levels

Y	N	
☐	☐	Diabetic
☐	☐	Patient > 70 yrs. old

Serum Creatinine results ***(must be drawn within the past 6 months):***

Sample Date: _____

Result: _____

eGFR: _____

Appointment Information

NON-OBSP: PLEASE FAX COMPLETED FORM to BREAST ASSESSMENT CENTRE: fax: **519-272-8247** Appointment date and time **will be faxed** back to your office.

APPOINTMENT DATE: _____

ARRIVAL TIME: MAMMO _____ **U/S** _____

Please notify your patient of the above appointment and have them **register at Imaging Reception** (East Building, 1st floor, North). **Patient should not wear deodorant**

****To change or cancel appointment, call 519-272-8210 ext. 2343****

Department Notes:

OBSP ONLY: Please have patient call **519-272-8210 ext.2339** to book the appointment **OR** fax requisition to **519-272-8247.**