

Please arrive 20 minutes before your appt. Late arrival may affect or cancel your appt.



Diagnostic Imaging Department

**BREAST IMAGING REQUISITION
Mammogram / Ultrasound**

Name: _____ M / F
 Address: _____
 Phone: (H) _____ (W) _____
 D.O.B. _____ Health Card #: _____
 Unit #: _____

APPOINTMENT

Date: _____ / _____ / _____
Date Month Year
Time: _____ a.m. _____ p.m.

Appointment LOCATION

- Georgetown** 1 Princess Anne Dr., Georgetown, ON L7G 2B8 Phone: 905-873-4596 Fax: 905-873-4593
- Milton** 725 Bronte Street S., Milton, ON L9T 9K1 Phone: 905-876-7023 Fax: 905-876-7003
- Oakville** 3001 Hospital Gate, Oakville, ON L6M 0L8 Phone: 905-338-4604 Fax: 905-845-9921

**All previous outside images AND reports must be onsite prior to booking.
 Incomplete requisitions will be returned and may result in a delay in service to your patients**

- Previous Mammogram Date: _____
- Previous Ultrasound Date: _____
- Completed At: _____

- Patient aware Halton Healthcare will leave test information on telephone
- Phone # _____

MAMMOGRAPHY- (check ONE box only)

- Routine Screening/OBSP
- Implants
- Previous Breast CA Screening
- 6-month follow-up of previous **Halton Healthcare** study
- New Mass – indicate on diagram* (typically requires US also)
- New Symptom – specify in clinical information

Abnormality detected by: Clinical Breast Exam

BREAST ULTRASOUND - (check ONE box only)

Please Fax requisition to DI

- Targeted ultrasound (indicate findings on diagram)
- Follow-up of previous **Halton Healthcare** study

* Bilateral breast screening ultrasound is not routinely performed at Halton Healthcare

For high risk screening, call: 1 800 668 9304 or visit <https://www.cancercare.on.ca/obsphighrisk>

BREAST INTERVENTION- (check ONE box only)

Please Fax requisition to DI

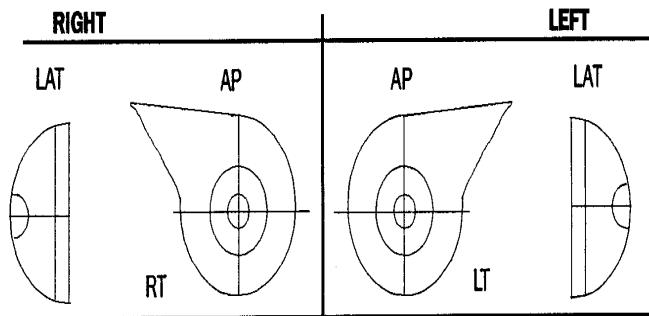
- Stereotactic biopsy
- Ultrasound guided biopsy
- Needle localization
- Clip placement: Node Breast
- Sentinel node injection

Based on outside images? Yes No

Is patient on blood thinners Yes No
 (please instruct patient appropriately)

**RELEVANT CLINICAL INFORMATION
(must be provided)**

LOCATION AND SIZE OF LESION



Referring physician: _____

Referring physician phone #: _____

Copy Report to: _____

Physician's Signature: _____

Date: _____

By NOT checking this box, I, as the referring physician, authorize and consent for the following tests to be scheduled for this patient on my behalf: breast ultrasound, special views, or image-guided biopsy.

