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

Halton Healthcare
GEORGETOWN · MILTON · OAKVILLE

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

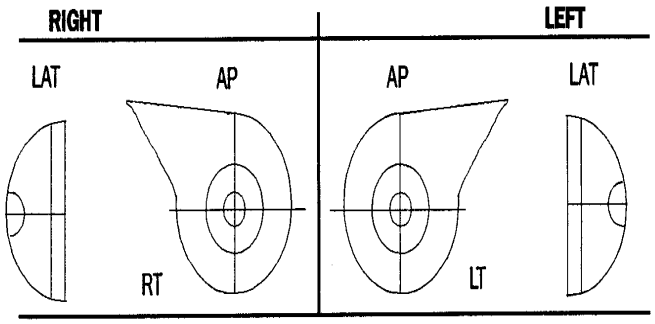
BREAST INTERVENTION- (check ONE box only)

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.***