

Medical Arts Building
 Diagnostic Imaging Centre
 581 Davis Drive, Level 3
 Newmarket, ON L3Y 2P6

Diagnostic Imaging MAB

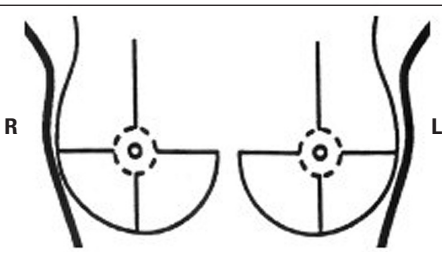
Referring Physician: (print first, last): _____
 CPSO# _____ Signature: _____
 Address: _____
 Office Phone: _____ Office Fax: _____
 Date: / /

Breast Imaging Requisition – Mammogram and Breast Ultrasound

Please fax to (905) 830-5981

Patient Name: (print first, last)			Date of Birth: <u> </u> / <u> </u> / <u> </u>
Address:	Street Number + Name	Apartment	Patient Weight: _____ kg
	City	Province	Cell: ()
		Postal Code	Home: ()
Health Card Number:	Version Code:		
Other Insurance:	Email:		
Patient DOES NOT consent to be contacted via: <input type="checkbox"/> Text <input type="checkbox"/> Email (for patient privacy information see the next page)			
Patient not available: From: <u> </u> / <u> </u> / <u> </u> To: <u> </u> / <u> </u> / <u> </u>			
Hoyer Lift Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient arriving by Ambulance Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
[NB: Consent to send copies can be implied if the recipients will be involved in ongoing follow-up care] I have obtained verbal or implied consent to send copies or results/notes to: <input type="checkbox"/> Family Doctor _____			
Relevant Clinical Information: (must be provided and please be specific)			

HAS YOUR PATIENT BEEN REFERRED TO THE BREAST CLINIC (DAU)? YES NO

Exam Required (Check all that apply) Fax Requisitions with Clinical Finding to (905) 830-5981	
 <p>INDICATE FINDINGS ON DIAGRAM.</p>	Reason for Exam: <input type="checkbox"/> New Mass* <i>*If ordering a mammogram for these symptoms, please also order a targeted breast ultrasound</i> <input type="checkbox"/> New Symptom* <input type="checkbox"/> General Lumpiness <input type="checkbox"/> General Pain <input type="checkbox"/> Other (Specify): _____ Does the patient have implants? <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Studies Previous Mammo? <input type="checkbox"/> Yes <input type="checkbox"/> No Previous Breast Ultrasound? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where (please attach reports if available):	
Breast Ultrasound <input type="checkbox"/> Targeted Ultrasound (must specify on diagram above) <input type="checkbox"/> Follow-up of Previous SRHC Study <input type="checkbox"/> Other (Specify):	Mammogram <input type="checkbox"/> Routine Screening (under 40 or personal history of breast cancer) <input type="checkbox"/> OBSP All eligible women, Two-Spirit, trans and nonbinary people (as indicated on second page) will be screened through the Ontario Breast Screening Program

PATIENT PREPARATIONS AND INFORMATION ON REVERSE SIDE. INCOMPLETE REQUISITIONS WILL BE RETURNED AND MAY RESULT IN A DELAY IN SERVICE TO YOUR PATIENT



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Breast Imaging Patient Preparation and Information

MAMMOGRAM PATIENT PREPARATION:

- If you have had any previous mammograms from another hospital or clinic, arrange to bring them with you for comparison purposes to expedite your results.
- Do not wear any deodorant, talcum powder, or perfume on the day of your examination.

ONTARIO BREAST SCREENING PROGRAM CRITERIA:

- Ontario Residents
- 40 years of age or over
- No acute breast symptoms
- No personal history of Breast Cancer
- Have not had a Mammogram within the last 11 months



Location Map

- V** Southlake Village, 640 Grace Street
- C** Stronach Regional Cancer Centre
- M** Medical Arts Building, 581 Davis Drive
- T** The Tannery Mall, 465 Davis Drive
- P** Parking
- H** Southlake Health
- Bridge over Davis Drive** - accessible from P3 of the Parking Garage and Level 3 of the Medical Arts Building.



PRIVACY POLICY DOCUMENTATION

via QR code link below or via Southlake's privacy office webpage