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166 BROCK STREET
KINGSTON, ON K7L 5G2
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BREAST ASSESSMENT PROGRAM

IMAGING REQUISITION

Appointment Date/Time:____________________

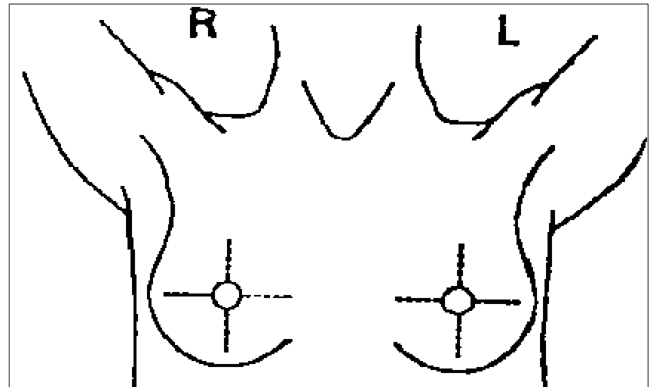
OBSPK#:____________________

CR#:
Name:
Date of Birth
Address:

Postal Code:
Home Tel#:
Business Tel #:
HN #:
Family Physician:

Right	Left	
☐	☐	**Routine Screening Mammogram**
☐	☐	**Mammogram** (for specific clinical abnormality)
☐	☐	**Cone compression**
☐	☐	**Cone magnification**
☐	☐	**Ultrasound**
☐	☐	**Ductogram**

Please indicate location of abnormality below



RADIOLOGY CONSULT FOR:

Right	Left	
☐	☐	**Image Guided Core Biopsy**
☐	☐	**Fine Needle Aspiration**
☐	☐	**Needle Localization/Specimen Radiograph**
☐	☐	**Sentinel Node Biopsy**

Abnormality Detected by:

☐ **Clinical Breast Exam**

☐ **Mammogram**

Previous Mammogram completed at:____________________ Date:__________

Clinical Information and History:

Is the patient taking blood thinners? ☐ **Yes** ☐ **No** **Please instruct your patient appropriately.**

Breast Implant? ☐ **Right** ☐ **Left**

Details of Current Findings:

____

____

____

I also agree that any of the following be arranged at the discretion of the Radiologist: core biopsy, fine needle aspiration or other breast imaging as required.

Physician signature:____________________

Physician name (print):____________________

Date:____________________

Send a copy of report to:

____

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