BRANT COMMUNITY HEALTHCARE SYSTEM

BREAST IMAGING REQUISITION

200 Terrace Hill St., Brantford ON N3R 1G9

Tel: 519-751-5599 Fax: 519-751-5532

For Office Use Only:
Appointment Date/Time:

REFERRING CLINICIAN INFORMATION

Name:

OHIP Billing Number:

Address

City/Prov: Postal Code:

Phone: Fax:

Signature:

Copies to:

PATIENT INFORMATION

Health Card Version

DOB (D D M M Y Y Y Y)

Sex (M F U)

First Name:

Last Name:

Address:

City/Province: Postal Code:

Phone Number: Secondary Phone Number:

PERTINENT HISTORY

Menstrual Status: _____

First Order Relative with Breast Ca: ☐Y ☐N

Specify: _____

Thyroid Medication: ☐Y ☐N
Birth Control Pills: ☐Y ☐N
Hormone Exposure: ☐Y ☐N

Does Patient Require:
Mechanical Lift ☐Y ☐N
Wheelchair ☐Y ☐N
Language Interpreter – Specify: _____

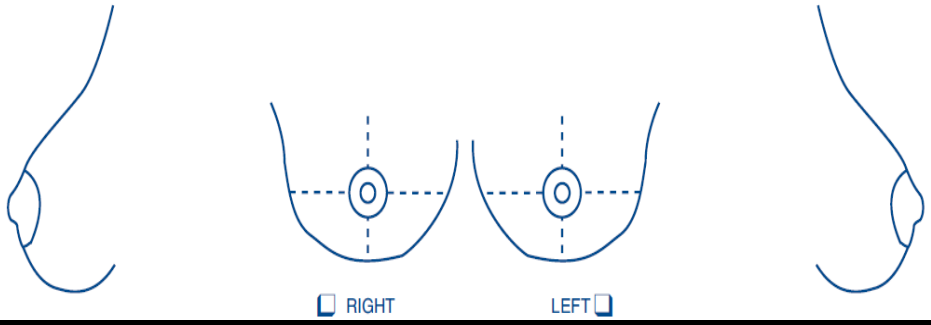
BY APPOINTMENT ONLY **INCOMPLETE REQUISITIONS WILL BE RETURNED**

☐Ductogram/Galactogram ☐L ☐R ☐B
☐Needle Localization ☐L ☐R ☐B
☐Sentinel Lymph Node Scan ☐L ☐R ☐B
☐Stereotactic Biopsy ☐L ☐R ☐B
☐Ultrasound Guided Biopsy ☐L ☐R ☐B

☐OBSP Mammogram
☐Routine Mammogram ☐L ☐R ☐B
☐Breast Implant ☐L ☐R ☐B
☐Diagnostic Mammogram ☐L ☐R ☐B
☐Breast Ultrasound ☐L ☐R ☐B

☐Contrast Enhanced Mammogram ☐L ☐R ☐B
Please complete for all CESM Requests.
Diabetic: ☐Y ☐N Metformin: ☐Y ☐N
Contrast Allergy: ☐Y ☐N Kidney Disease: ☐Y ☐N
eGfr: _____ Date Collected: _____ DD/MM/YY

Is patient on blood thinners? ☐Y ☐N Specify: _____



CLINICAL HISTORY

OUTSIDE PREVIOUS AND BREAST SURGICAL HISTORY

Previous Surgeries:

Related Previous Imaging: ☐ Yes ☐ No If yes, Where:
Please attach previous reports if not completed at BGH.

FOR IMAGING USE ONLY

Right	Clinical Information	Left

PLEASE ADVISE PATIENT NOT TO WEAR DEODORANT, BODY LOTION OR TALCUM POWDER TO THIS APPOINTMENT