Hôpital général de la baie Georgienne
GEORGIAN BAY General Hospital

Diagnostic Imaging Request- Ultrasound
TEL. (705) 526-1300 FAX. (705) 526-7837
BY APPOINTMENT ONLY

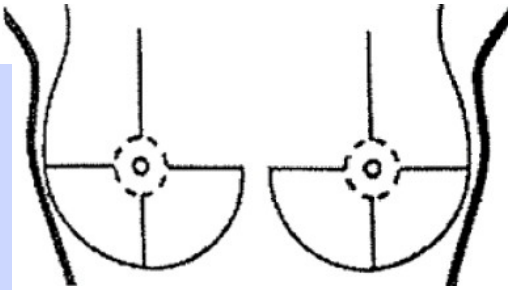
Name: F☐ M☐
Address:
City: Postal Code:
Health Card #:
Date of Birth (DD/MM/YYYY): / /
Home #: Cell #:

Please allow 2 weeks to receive notification of appointments

APPOINTMENT DATE: **TIME:**

RELEVANT CLINICAL INFORMATION

Must be provided with specific details and indicated on diagram



Please ensure to document specific location of nodule to be localized in diagram

☐ **NO** Previous Imaging
☐ Previous Breast Imaging
Date:
Location:

☐ Previous Breast Cancer
☐ Pregnant
☐ Breast Feeding
☐ Implants

Please indicate your request type below then mark the relevant study options beneath your selection

☐ **MAMMOGRAPHY**
- ☐ OBSP
- ☐ Routine Screening
- ☐ Follow-up of previous study ☐R ☐L

Diagnostic
- ☐ New mass ☐R ☐L
- ☐ Clear/bloody nipple discharge ☐R ☐L

☐ **BREAST ULTRASOUND**
- ☐ Targeted ultrasound ☐R ☐L
- ☐ Follow-up of previous study ☐R ☐L

☐ **BIOPSY REQUEST**
- ☐ Ultrasound guided biopsy ☐R ☐L
- ☐ Stereotactic core biopsy ☐R ☐L

☐ **PRE-SURGICAL LOCALIZATION**
- ☐ Ultrasound ☐R ☐L
- ☐ Mammography ☐R ☐L

- Please ensure any breast imaging is provided for comparison
- Please notify patient of their appointment time and date
- ***Failure to do either of the above may result in a delay of examination results***

Referring Physician: *(print first, last)*	**Date:**
Signature:	**Office Phone:**
Address:	**Fax Number:**
Physician OHIP Billing #:	**CPSO #:**