



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

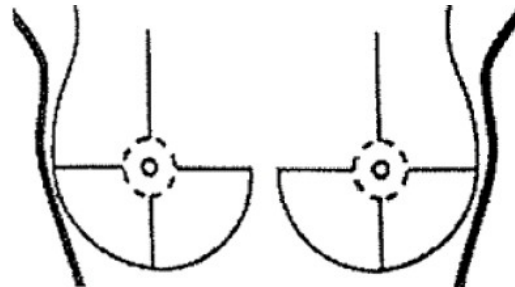
Name: _____ F _____ M _____
 Address: _____
 City: _____ Postal Code: _____
 Health Card #: _____
 Date of Birth (DD/MM/YYYY): _____ / _____ / _____
 Home #: _____ Cell #: _____

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

- | | |
|---|---|
| <input type="checkbox"/> NO Previous Imaging | <input type="checkbox"/> Previous Breast Cancer |
| <input type="checkbox"/> Previous Breast Imaging | <input type="checkbox"/> Pregnant |
| Date: _____ | <input type="checkbox"/> Breast Feeding |
| Location: _____ | <input type="checkbox"/> Implants |

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

MAMMOGRAPHY

- | | | |
|--|----------------------------|----------------------------|
| <input type="checkbox"/> OBSP | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Routine Screening | | |
| <input type="checkbox"/> Follow-up of previous study | <input type="checkbox"/> R | <input type="checkbox"/> L |
| Diagnostic | | |
| <input type="checkbox"/> New mass | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Clear/bloody nipple discharge | <input type="checkbox"/> R | <input type="checkbox"/> L |

BREAST ULTRASOUND

- | | | |
|--|----------------------------|----------------------------|
| <input type="checkbox"/> Targeted ultrasound | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Follow-up of previous study | <input type="checkbox"/> R | <input type="checkbox"/> L |

BIOPSY REQUEST

- | | | |
|---|----------------------------|----------------------------|
| <input type="checkbox"/> Ultrasound guided biopsy | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Stereotactic core biopsy | <input type="checkbox"/> R | <input type="checkbox"/> L |

PRE-SURGICAL LOCALIZATION

- | | | |
|--------------------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> R | <input type="checkbox"/> L |
| <input type="checkbox"/> Mammography | <input type="checkbox"/> R | <input type="checkbox"/> 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 Billing Number:	