British Columbia Radiological Society
Section of Radiology
BC Medical Association

# STANDARD OUT-PATIENT BREAST IMAGING REQUISITION

WEST COAST MEDICAL IMAGING

430 -1669 East Broadway
Vancouver BC
**TEL: 604-873-1846**
**FAX: 604-873-6318**

104 -8425 120th Street
Delta BC
**TEL: 604-590-2211**
**FAX: 604 581-0405**

X-RAY USE ONLY

BILLABLE TO:
❑ MSP ❑ ICBC ❑ WCB ❑ PATIENT ❑ OTHER

NAME OF PHYSICIAN & MSP PRACTITONER NUMBER (or office stamp)

PERSONAL HEALTH NUMBER

DOB: YYYY/ MM / DD

SURNAME OF PATIENT

FIRST NAME AND MIDDLE INITIAL

TELEPHONE # (INCLUDE AREA CODE)

GENDER ❑ M ❑ F

PREGNANT ❑ Yes ❑ No

ADDRESS

CITY / TOWN

POSTAL CODE

COPY RESULTS TO

❑ **DIAGNOSTIC MAMMOGRAPHY** ❑ **ULTRASOUND**

❑ Proceed to further imaging if indicated (mammography or ultrasound)

❑ Call me if further investigation is necessary

**Preparation: please do not wear deodorant, talcum powder or scented products**

## HISTORY

| | |
|---|---|
| PREVIOUS MAMMOGRAMS ❑ YES ❑ NO | DATE(S) |
| PREVIOUS BIOPSIES / SURGERY ❑ YES ❑ NO | DATE(S) |
| HORMONE THERAPY ❑ YES ❑ NO | DATE(S) |
| FAMILY HISTORY OF BREAST CANCER ❑ YES ❑ NO | RELATIONSHIP |
| MENSTRUAL HISTORY LMP (DATE): | MENOPAUSE (AGE) |

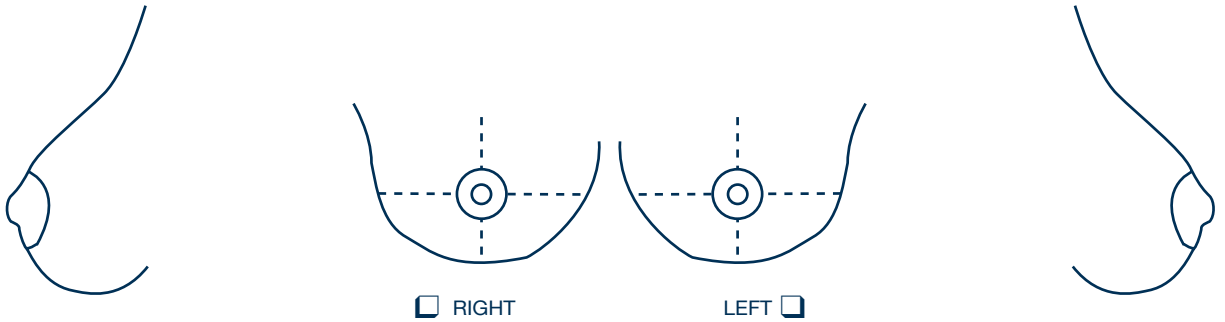
## PRESENT COMPLAINT (Please check the appropriate indication)

❑ LUMP ❑ THICKENING ❑ LOCALIZED PAIN TENDERNESS ❑ NIPPLE DISCHARGE

❑ ABNORMAL SCREENING MAMMOGRAM ❑ FOLLOW UP OF PREVIOUS FINDINGS ❑ PREVIOUS BREAST CANCER ❑ BREAST PROSTHESES (IMPLANTS )

❑ OTHER SPECIFICS

## PLEASE MARK AREA(S) OF CONCERN WHEN APPROPRIATE



❑ RIGHT LEFT ❑

SIGNATURE OF REQUESTING PHYSICIAN

Appt Date: _____ Time: _____