BRITISH COLUMBIA

British Columbia Radiological Society
Section of Radiology
BC Medical Association

STANDARD OUT-PATIENT BREAST IMAGING REQUISITION

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

105 - 8318, 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

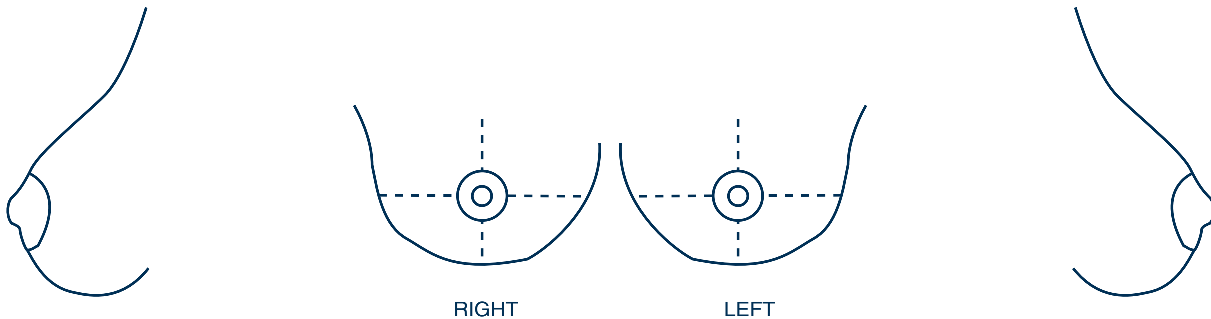
HISTORY

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



SIGNATURE OF REQUESTING PHYSICIAN

Appt Date: ______________________ Time: ______________