British Columbia Radiological Society
Section of Radiology
BC Medical Association

STANDARD OUT-PATIENT BREAST IMAGING REQUISITION

WEST COAST MEDICAL IMAGING

#301 - 1990 Fort St. Victoria, BC V8R 6V4

Central Booking: (250) 412 - 1780

Fax Requisition to: (250) 412 - 1782

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**

❒ 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)

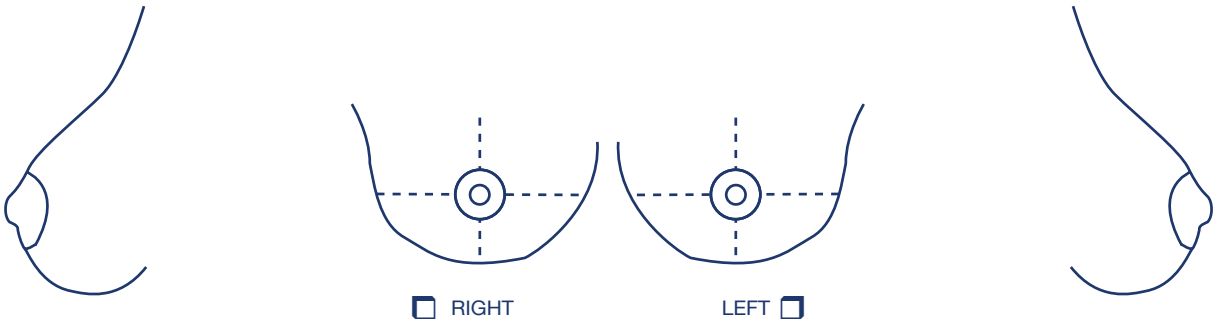
PRESENT COMPLAINT (Please check the appropriate indication)

❒ 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: _____

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1990 FORT STREET LOCATION