SHN SCARBOROUGH HEALTH NETWORK

Request for

Breast Imaging

☐ Outpatient ☐ Inpatient ☐ ED loc. ________

☐ **BIRCHMOUNT**
3030 Birchmount Road
Scarborough, ON M1W 3W3

☐ **CENTENARY**
2867 Ellesmere Road
Scarborough, ON M1E 4B9

☐ **GENERAL**
3050 Lawrence Ave East
Scarborough, ON M1P 2V5

PHONE 416-431-8167 **FAX** 416-431-8141

Outpatient requests will be given first available at any department unless specified

PATIENT INFORMATION

Name ______________________________ Date of birth ____________________ Sex ☐ F ☐ M ☐ Other
Last name, First name *Day-Month-Year*

Health card ____________________ Version code ______ Hospital ID ______________________

Address ____

City ________________ Postal code ________ Phone 1 ______________ Phone 2 ______________
Preferred *Alternate*

MAMMOGRAPHY AND ULTRASOUND

OBSP screening mammogram ☐ Bilateral
Age 50+, no previous breast cancer, no implants, no acute symptoms

Screening mammogram (other) ☐ Bilateral ☐ Right ☐ Left
OBSP-ineligible patients, no acute symptoms

Diagnostic mammogram ☐ Bilateral ☐ Right ☐ Left
E.g. Symptomatic, lump, work-up, radiologist-recommended follow-up

Diagnostic ultrasound ☐ Bilateral ☐ Right ☐ Left
Not performed for routine screening, surveillance, or follow-up of benign cysts

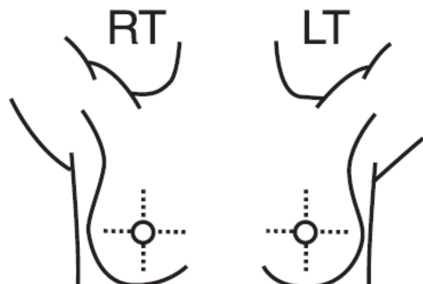
INTERVENTIONAL PROCEDURES

Ultrasound-guided biopsy ☐ Right ☐ Left
Stereotactic biopsy ☐ Right ☐ Left
Ductogram ☐ Right ☐ Left
Ultrasound-guided needle localization ☐ Right ☐ Left
Mammography-guided needle localization ☐ Right ☐ Left
Sentinel node ☐ Right ☐ Left

BONE MINERAL DENSITY

☐ Baseline ☐ Low risk (> 36 months) ☐ High risk (> 12 months)

CLINICAL INDICATION/RELEVANT HISTORY



Indicate areas of concern on diagram

SCREENING

Requires accessibility considerations (e.g. wheelchair) ...... ☐ Y ☐ N

If yes, specify ________________

Additional breast imaging performed outside SHN .... ☐ Y ☐ N

If yes, relevant priors with reports must be sent with patient or directly to the selected SHN site

BILLING

☐ OHIP ☐ WSIB claim # ____________ ☐ Other ____________

REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Send copies to:

Signature ✗ ____________________ Date ____________

Incomplete or unsigned requests will be returned and may result in delay