HPHA BREAST CENTRE

BREAST IMAGING CONSULTATION

Name: _____

DOB: _____ID Number: _____

Pt. Phone Number: _____HC# _____

Clinical Information ***(mandatory)*** _____

_____

_____

_____ MD NP PA _____ _____

Referring Clinician ***(please print)*** **Clinician's Signature** ***(mandatory)*** Date

CC Copies to: _____ Clinician's Phone# _____

Essential History

Previous Mammo	Yes ☐	No ☐	When: _____	Where:	☐ SGH	☐other (specify) _____
Previous Breast US	Yes ☐	No ☐	When: _____	Where:	☐ SGH	☐other (specify) _____
Previous Breast MRI	Yes ☐	No ☐	When: _____	Where:	☐ SGH	☐other (specify) _____
Previous breast cancer	Yes ☐	No ☐	R or L When: _____			
Breast implants	Yes ☐	No ☐				
Patient pregnant	Yes ☐	No ☐				
Patient breastfeeding	Yes ☐	No ☐				

Reason for Investigation

☐Screen *(regular check-up/no problems)* ☐OBSP *(40 and over)

☐Surveillance/check-up for prior breast cancer

☐Follow-up evaluation of a prior Mammogram or US finding

☐New problem: Onset of symptoms?

- ☐ Breast lump R ☐ L ☐ _____
- ☐ Thickening R ☐ L ☐ _____
- ☐ Pain/tenderness R ☐ L ☐ _____
- ☐ Nipple discharge R ☐ L ☐ _____

Studies Requested

☐Mammogram ☐Bilateral R ☐ L ☐

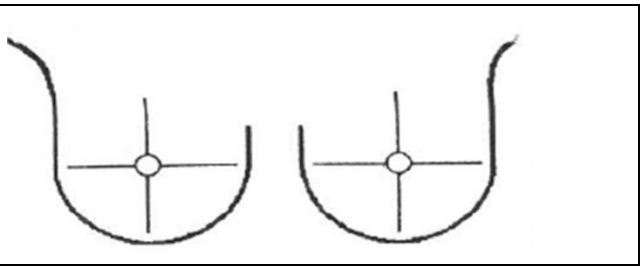
☐Breast Ultrasound R ☐ L ☐

☐US-guided aspiration or biopsy R ☐ L ☐

☐Stereotactic core biopsy R ☐ L ☐

☐Pre-Op Needle Localization under: ☐ US ☐Mammo R ☐ L ☐

☐Lumpectomy ☐Mastectomy Date_____



Contrast Enhanced Mammography

Weight: kg/lbs._____

Can the patient consent for the procedure? **Y ☐ N ☐**

If No, please provide the Name and Contact Number of the Substitute Decision Maker/Power of Attorney:

_____

Allergy to X-ray dye/ IV Contrast? **Y ☐ N ☐**

If Yes, please describe type of reaction:

_____

Renal Assessment

** If Yes to any of the following risk factors, a Creatinine result from within the last 6 months must be provided.

History or Renal Impairment/ Nephrectomy:	**Y ☐ N ☐**
Patient 70+ years old:	**Y ☐ N ☐**
Diabetes Mellitus:	**Y ☐ N ☐**
Dialysis:	**Y ☐ N ☐**
Does the patient have any other conditions or Medications that may predispose to nephrotoxicity:	**Y ☐ N ☐**

Serum Creatinine results:

Sample Date: _____

Result: _____µmol/L

eGFR: _____

Appointment Information

NON-OBSP: PLEASE FAX COMPLETED FORM to BREAST ASSESSMENT CENTRE:
fax: **519-272-8247** Appointment date and time **will be faxed** back to your office.

APPOINTMENT DATE: _____

ARRIVAL TIME: MAMMO _____ **U/S** _____

Please notify your patient of the above appointment and have them **register at Imaging Reception** (Stratford General Hospital, East Building, 1st floor, North). **Patient should not wear deodorant**

****To change or cancel appointment, call 519-272-8210 ext. 2343****

Department Notes:

OBSP ONLY: Please have patient call **519-272-8210 ext.2339** to book the appointment **OR** fax requisition to **519-272-8247.**