Orillia Soldiers' Memorial Hospital
170 Colborne St. West, Orillia, ON L3V 2Z3 Tel: **705-327-9127** Fax: **705-330-3224**

Request for Mammography / Bone Density Examination

(By Appointment Only)

	MRN No.	**APPOINTMENT DATE:**	**TIME:**
PATIENT INFORMATION			**ARRIVAL TIME:**

Last Name		**First Name**		
Date of Birth (d/m/y)	☐ M ☐ F	**Health Card No.**	**WSIB No.**	**3rd Party Ins. No.**
Address				
City	**Postal Code**	**Contact Number**	☐ **OK to leave voice mail message**	

BREAST IMAGING

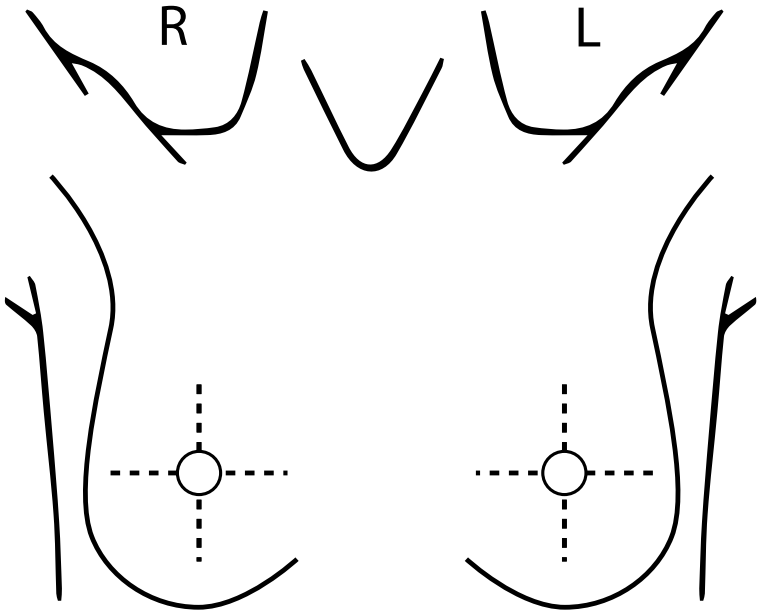
- ☐ MAMMOGRAM BILATERAL
- ☐ MAMMOGRAM UNILATERAL ☐ LEFT ☐ RIGHT
- ☐ OBSP
- ☐ STEREOTACTIC BREAST BIOPSY ☐ LEFT ☐ RIGHT
- ☐ BREAST ULTRASOUND ☐ LEFT ☐ RIGHT

☐ OTHER EXAMINATION NOT LISTED:

PREVIOUS EXAM DATE:

PREVIOUS LOCATION:

PLEASE TARGET AREA OF CONCERN:



BONE MINERAL DENSITY

- ☐ BONE MINERAL DENSITY HIGH RISK
- ☐ BONE MINERAL DENSITY LOW RISK

PREVIOUS EXAM DATE:

PREVIOUS LOCATION:

RELEVANT CLINICAL HISTORY
FOR BREAST IMAGING and/or BONE MINERAL DENSITY EXAM:

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)	OFFICE STAMP:
Address/ Phone	**CPSO#**
Physician's Signature X	

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.