Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

REQUEST FOR

Mammography / Bone Density Exam

Tel: **705-327-9127** Fax: **705-330-3224**

• BY APPOINTMENT ONLY •

PATIENT INFORMATION	MRN N0.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**
Last Name		First Name	☐ M ☐ F
Date of Birth (D/M/Y)	Health Card N0.	WSIB N0.	3rd Party Ins. N0.
Address			
City	Postal Code	Contact Number	**OK to leave voice mail message**

Patient is able to give consent for this procedure: ☐ Yes ☐ No

Does the patient have a glucose monitoring device? ☐ Yes ☐ No

If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.

☐ **SDM Name:** ☐ **SDM Contact Information:**

☐ **Patient requires assistance to complete this imaging exam,** *e.g. mobility, translation* **Please Specify:**

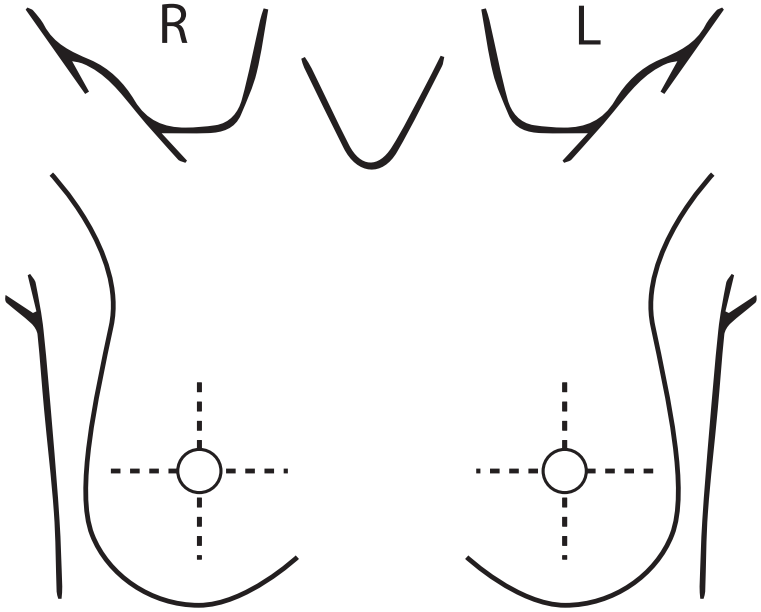
BREAST IMAGING

- ☐ MAMMOGRAM BILATERAL
- ☐ MAMMOGRAM UNILATERAL ☐ LEFT ☐ RIGHT
- ☐ OBSP
- ☐ STEREOTACTIC BREAST BIOPSY ☐ LEFT ☐ RIGHT
- ☐ BREAST ULTRASOUND ☐ LEFT ☐ RIGHT
- ☐ ULTRASOUND GUIDED BREAST BIOPSY ☐ 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's Name
(Please PRINT clearly)

Phone **CPSO#**

Physician's Signature

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