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 No.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER		**ARRIVAL TIME:**	

Last Name	First Name	☐ M ☐ F

Date of Birth (D/M/Y)	Health Card No.	WSIB No.	3rd Party Ins. No.

Address	City	Postal Code

Email Address	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

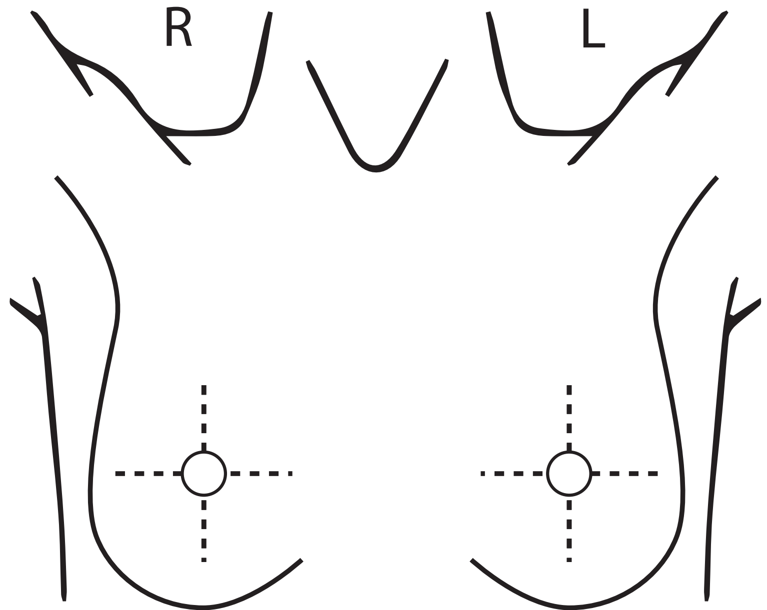
☐ ULTRASOUND GUIDED BREAST BIOPSY ☐ LEFT ☐ RIGHT

☐ 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)		Physician's Signature
Phone	**CPSO#**	

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

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