



REQUEST FOR Mammography / Bone Density Exam

• BY APPOINTMENT ONLY •

Tel: 705-327-9127 Out-Patient Fax: 705-330-3224 In-Patient Fax: 705-325-0582

PATIENT INFORMATION		MRN N ^o .	Isolation Status	
<input type="checkbox"/> IN-PATIENT	<input type="checkbox"/> OUT-PATIENT	<input type="checkbox"/> ED	<input type="checkbox"/> AHF	
Last Name		First Name		<input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth (D/M/Y)	Health Card N ^o .	WSIB N ^o .	3rd Party Ins. N ^o .	
Address		City	Postal Code	
Email Address		Contact Number	<input type="checkbox"/> OK to leave voice mail message	
Patient is able to give consent for this procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a glucose monitoring device? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If patient unable to give consent, please ensure SDM attends with the patient and has appropriate documentation.				
<input type="checkbox"/> SDM Name:		<input type="checkbox"/> SDM Contact Information:		
<input type="checkbox"/> 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:

BONE MINERAL DENSITY

- BONE MINERAL DENSITY

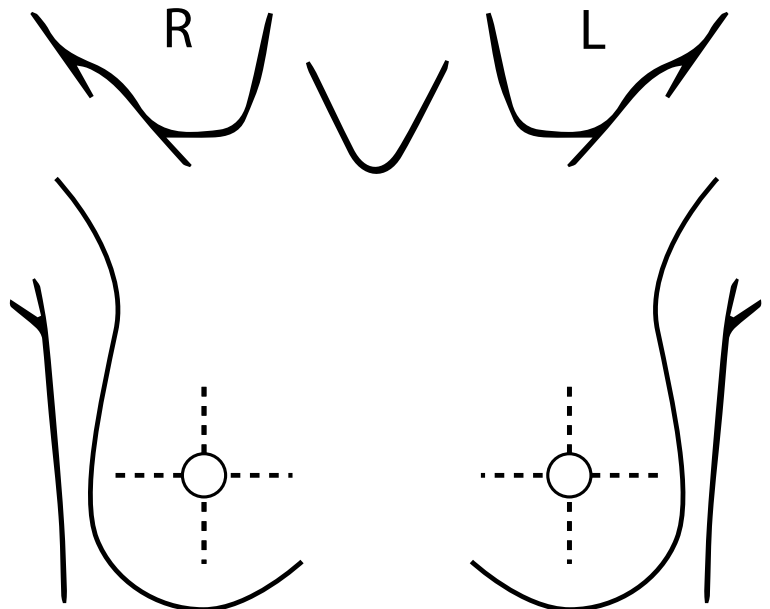
PATIENT RISK FACTOR SCREENING

- Has the patient been treated with medicine for osteoporosis? YES NO
- Is the patient currently on any steroid medications? YES NO

PREVIOUS EXAM DATE:

PREVIOUS LOCATION:

AREA OF CONCERN MUST BE INDICATED:



CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION

(Must be provided and must be specific)

Physician's Name <small>(Please PRINT clearly)</small>	Phone #	CPSO #
Address	Fax #	
INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.		
Physician's Signature		