Soldiers' MEMORIAL HOSPITAL Orillia

ISO 15189 Plus™ Accredited IQMH Diagnostic Imaging

REQUEST FOR

Mammography

• 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

☐ IN-PATIENT ☐ OUT-PATIENT ☐ ED ☐ AHF

Last Name	First Name	☐ M ☐ 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	☐ 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

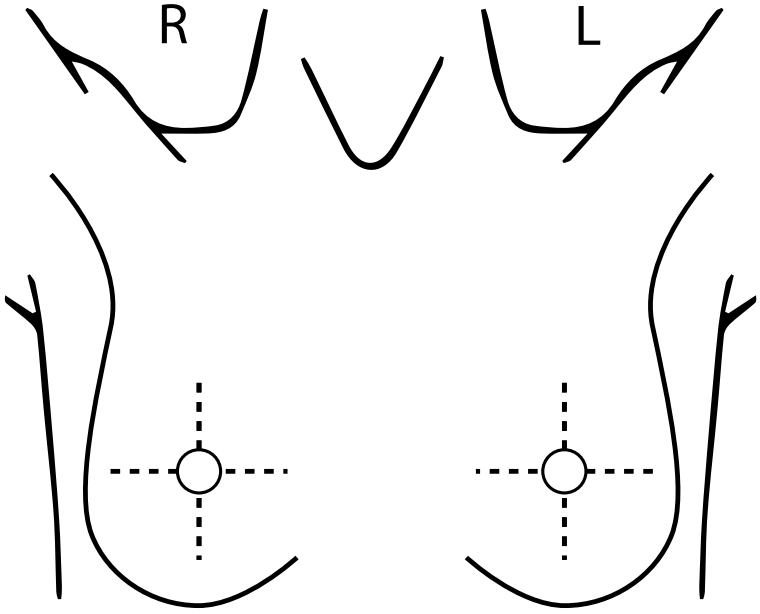
☐ ULTRASOUND GUIDED BREAST BIOPSY ☐ LEFT ☐ RIGHT

OTHER EXAMINATION NOT LISTED:

PREVIOUS EXAM DATE:

PREVIOUS LOCATION:

AREA OF CONCERN MUST BE INDICATED:



CLINICAL QUESTION AND RELEVANT CLINICAL INFORMATION
(Must be provided and must be specific)

Physician's Name (Please PRINT clearly)	Phone #	CPSO #
Address	Fax #	Physician's Signature

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

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