ST. JOSEPH'S
UNITY HEALTH TORONTO

MAMMOGRAPHY, BREAST ULTRASOUND AND BONE MINERAL DENSITOMETRY

P000197

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name: _____
Male Female
MRN: _____
DOB: _____
Address: _____

Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

EXAMINATION(S) REQUESTED ☐ STAT ☐ URGENT ☐ ROUTINE

Mammography: _____ **Breast Ultrasound:** _____

☐ Right ☐ Left ☐ Bilateral ☐ Right ☐ Left ☐ Bilateral

Ordering physician consents to biopsy if recommended by Radiologists ☐ Yes

Date/Location of Last Mammogram: _____ **Date/Location of Last Breast Ultrasound:** _____

Previous Mammogram has been sent to SJHC: ☐ Yes **Previous Breast Ultrasound Imaging has been sent to SJHC:** ☐ Yes

Previous Breast MRI: ☐ Yes ☐ No **Date/Location:** _____

Bone Mineral Density: ☐ High Risk ☐ Low Risk ☐ Baseline **Date/Location of Last BMD:** _____

Current Weight: _____ **Current Height:** _____

Current Patient Location: ☐ Outpatient ☐ Clinic/ACC ☐ Emergency ☐ Inpatient

WSIB/Third Party Claim Number: _____ **Preferred Days/Time (not guaranteed):** _____

CLINICAL HISTORY

Isolation Precautions: ☐ N/A ☐ Contact ☐ Droplet ☐ Airborne ☐ Reverse

ADDITIONAL INFORMATION

Date of Last Menstrual Period: _____ ☐ N/A

☐ Falls Risk ☐ Lifting Device Required ☐ Patient with Restraints (must be accompanied)

Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No

Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No

Contact Telephone Number (if different from above): _____

REQUESTING PHYSICIAN

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____

Copy to: _____ MD (Physician's Printed Name)

DATE/TIME	SIGNATURE	PRINT NAME
DD / Month / YYYY : h		

Reset Form