ST. JOSEPH'S
UNITY HEALTH TORONTO

P000197

MAMMOGRAPHY, BREAST ULTRASOUND AND BONE MINERAL DENSITOMETRY

Breast Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Breast Booking ONLY: 416-530-2085
Breast Fax: 416-530-2084
BMD Booking ONLY: 416-530-6213
BMD Fax: 416-530-6799

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 ☐ No

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

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

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

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

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

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

Contact Telephone Number (if different from above):

REQUESTING PHYSICIAN

Address: _____ City: _____ Postal Code: _____

Phone Number: _____ Fax: _____

Copy to: MD (Physician's Printed Name)

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