

# MAMMOGRAM REQUISITION

## NORFOLK GENERAL HOSPITAL

365 West St, Simcoe, ON N3Y 1T7

Phone (519) 429-6974 Fax (519) 429-6992

**\*\*BRING THIS REQUISITION\*\***

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ DD/MM/YY  
 HEALTH CARD#: \_\_\_\_\_  
 PHONE: \_\_\_\_\_

### REASON FOR PRESENT EXAMINATION:

Screening Yes  No   
 Implants Yes  No

	Right	Left
FOCAL Pain/Tenderness? <b>*MUST be marked on diagram*</b>		
Palpable lump? <b>Felt by Patient <input type="checkbox"/> Felt by Dr. <input type="checkbox"/></b> <b>*MUST be marked on diagram*</b>		
Skin redness/dimpling?		
Nipple Discharge Clear? <input type="checkbox"/> Milky? <input type="checkbox"/> Bloody? <input type="checkbox"/>		

### HISTORY (FOR TECHNOLOGIST)

Hormone replacement therapy(HRT)? Yes  No  If yes for how many years? \_\_\_\_\_  
 Family history of breast cancer? Yes  No  If yes who? \_\_\_\_\_  
 Previous breast surgery? Yes  No  Right or Left \_\_\_\_\_ when \_\_\_\_\_  
 Radiation? Yes  No  Chemotherapy? Yes  No

Appointment DATE: \_\_\_\_\_

Appointment TIME: \_\_\_\_\_

**\*\*\*ARRIVE 15 MINUTES BEFORE APPOINTMENT\*\***  
**\*\*\*DO NOT wear deodorant, lotion or powder\*\*\*\*\***

Previous Mammogram? Yes  No   
 Where? \_\_\_\_\_ When? \_\_\_\_\_  
 Previous Breast Ultrasound? Yes  No   
 Where? \_\_\_\_\_ When? \_\_\_\_\_

### Patient Mobility:

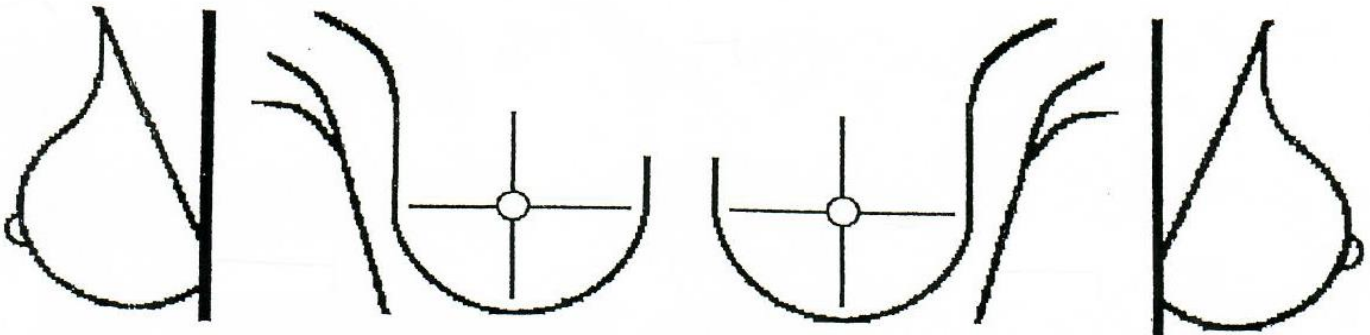
Ambulatory  Wheelchair  Other: \_\_\_\_\_

### ANY NEW SYMPTOMS? Please list below:

Clinical information:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Physician Name (Please Print): \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_

### Technologist Comments:

### Radiologist Protocol:



RIGHT

LEFT