Eastern Health
Diagnostic Imaging

Request for Mammography Exam and Consultation

Name: ______________________

HCN: ______________________

Date of Birth: DD/MONTH/YYYY

Address: ______________________
Street/Town/Postal Code

Telephone: ______________________

❑ Inpatient – Unit ________ ❑ Outpatient

Is patient mobility restricted? ❑ Yes ❑ No

Patient Transport: ❑Bed ❑Stretcher ❑ Wheelchair

❑ MCP ❑ WCC ❑ NR ❑ DVA ❑ DND ❑ Other: ________

Physician Information (please use stamp)

The ordering physician is responsible to follow-up on the exam report.

Physician Signature: ______________________

Date: DD/MONTH/YYYY

Copy report to (please print): ______________________

Type of Exam Required

Specific Exam Requested: ______________________

Please Identify Urgency
Based on clinical assessment, Radiologist consult may be indicated.

❑ Urgent
❑ Non-urgent
❑ Follow-up (Specify Date): DD/MONTH/YYYY
❑ Screening (Specify Date): DD/MONTH/YYYY

Please indicate whether exam is being requested for a specific site or first available appointment. Please note that requesting a specific site may result in a longer wait time.

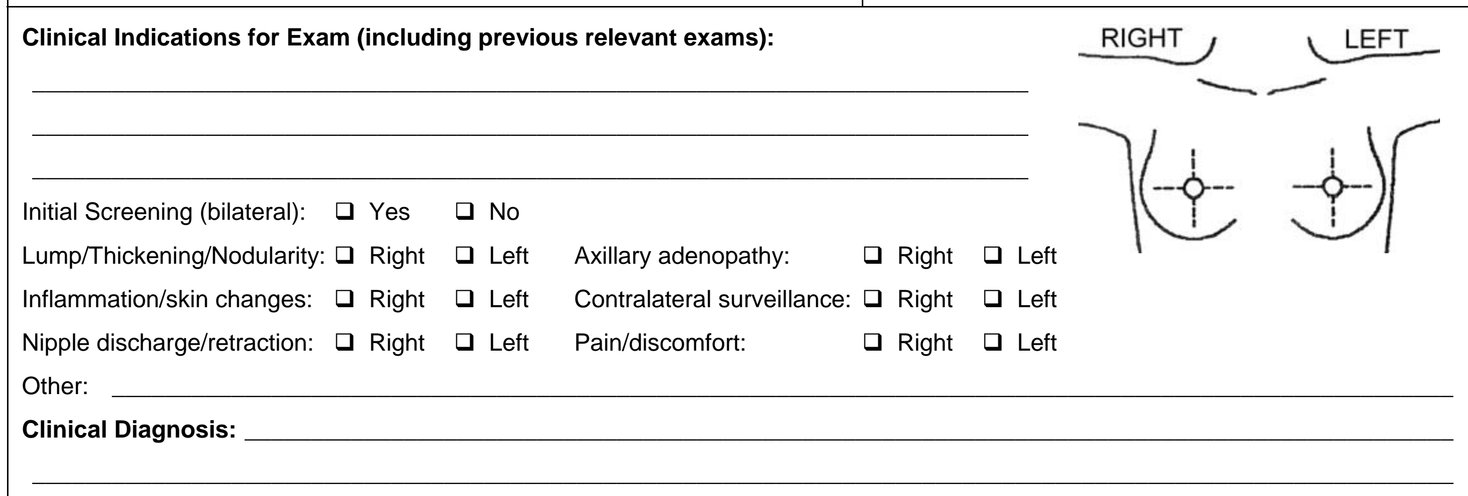
❑ First Available Appointment ❑ Specific Site (indicate site): ______________________

Clinical Information

Does patient have breast implants? ❑ Yes ❑ No
Is patient on Warfarin, ASA or other anticoagulant? ❑ Yes ❑ No
Please list any other relevant patient medications:
____

Please list allergies: ❑ None
____

Date and location of last mammogram:
DD/MONTH/YYYY



Clinical Indications for Exam (including previous relevant exams):

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Initial Screening (bilateral): ❑ Yes ❑ No

Lump/Thickening/Nodularity: ❑ Right ❑ Left

Inflammation/skin changes: ❑ Right ❑ Left

Nipple discharge/retraction: ❑ Right ❑ Left

Axillary adenopathy: ❑ Right ❑ Left

Contralateral surveillance: ❑ Right ❑ Left

Pain/discomfort: ❑ Right ❑ Left

Other: ______________________

Clinical Diagnosis: ______________________

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For Diagnostic Imaging Use Only

Ordering Physician Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

Date Received: DD/MONTH/YYYY

Patient Preparation Instructions: ❑ *Yes* ❑ *No*

Patient Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

Exam Protocol: ______________________

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