Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

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BREAST
IMAGING REQUISITION

Appointment Date/Time:______________________________________

OBSPK#:____

CR#:
Name:
Date of Birth
Address:

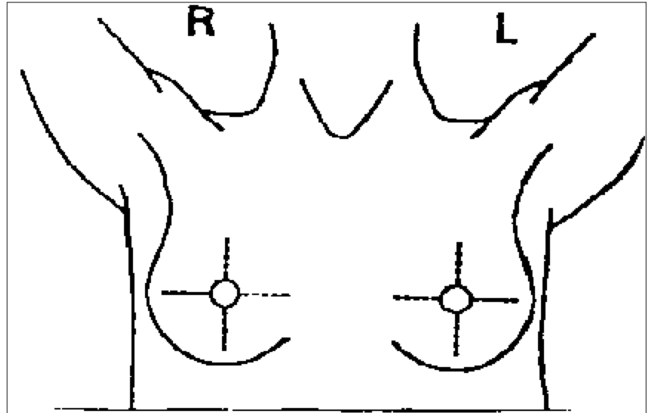
Postal Code:
Home Tel#:
Business Tel #:
HN #:
Family Physician:

Right	Left	
☐	☐	**Routine screening mammogram**
☐	☐	**Mammogram** (for specific clinical abnormality)
☐	☐	**Cone compression**
☐	☐	**Cone magnification**
☐	☐	**Ultrasound**
☐	☐	**Ductogram**

RADIOLOGY CONSULT FOR:

Right	Left	
☐	☐	**Image Guided Core Biopsy**
☐	☐	**Fine needle aspiration**
☐	☐	**Needle Localization/Specimen Radiograph**
☐	☐	**Sentinel Node Biopsy**

Please indicate location of abnormality below



Abnormality Detected by:

☐ **Clinical Breast Exam**

☐ **Mammogram**

Previous Mammogram completed at:______________________________ Date:__________

Clinical Information and History:

Is the patient taking blood thinners? ☐ **Yes** ☐ **No** **Please instruct your patient appropriately.**

Breast Implant? ☐ **Right** ☐ **Left**

Details of Current Findings:

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I also agree that any of the following be arranged at the discretion of the Radiologist: core biopsy, fine needle aspiration or other breast imaging as required.

Signature: ______________________________**for**_____________

Physician name (print): ___________________________________

Date: ____

Send a copy of report to:

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