BREAST IMAGING REQUISITION

Appointment Date/Time:_______________________________________

OBSPK#:____________________________________

Right        Left

CR#:

Routine screening mammogram
Mammogram (for specific clinical abnormality)
Cone compression
Cone magnification
Ultrasound
Ductogram

RADIOLOGY CONSULT FOR:

Image Guided Core Biopsy
Fine needle aspiration
Needle Localization/Specimen
Radiograph
Sentinel Node Biopsy

Abnormality Detected by:

☐ Clinical Breast Exam
☐ Mammogram

Please indicate location of abnormality below

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:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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):______________________________

Send a copy of report to:

________________________________________________________________________

Date: __________________________

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