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

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Breast Imaging Kingston site
820 John Marks Ave, KINGSTON, ON K7K 0J7
TEL: (613) 384-4284 FAX: (613) 544-2504

BREAST IMAGING REQUISITION

Appointment Date/Time:_____

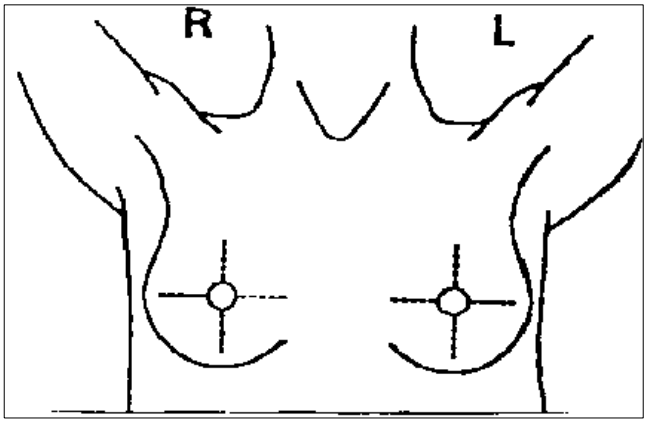
OBSPK#:_____

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**

Please indicate location of abnormality below



RADIOLOGY CONSULT FOR:

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

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:

_____

_____

_____

_____

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:

_____

_____

_____