STEVENSON MEMORIAL HOSPITAL

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FOR BOOKINGS ONLY

Patient Notified ☐ LVM ☐ Date: _____
Appt. Date/Time: _____ Prep Explained ☐
Notes: _____

MAMMO-BMD ULTRASOUND REQUISITION FOR OUTPATIENT REFERRAL

PATIENT LABEL

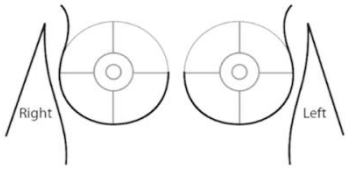
Clinical History/Indication
Reason for exam

Patient Name:	DOB: (dd/mm/yyyy)	OHIP #:	VC:
Address:		Phone:	
Referring Physician: (print)	Phone:	Fax:	
Physician's Signature:		Date of Referral: (dd/mm/yyyy)	

BREAST IMAGING

Mammography	Ultrasound	Interventional (includes Consul)
☐ Diagnostic Mammography ☐ Screening Mammography (OBSP) ☐ Screening Mammography (Non-OBSP)	☐ R ☐ L Breast Ultrasound	☐ R ☐ L Ultrasound Guided Biopsy ☐ R ☐ L Ultrasound Guided Needle Localization

Patient Screening

Breast Implants	☐ R ☐ L ☐ Bilateral ☐ N/A	**Please indicate findings on diagram:**
Prior Breast Ca	☐ R ☐ L ☐ Bilateral ☐ N/A	
Symptomatic	☐ R ☐ L ☐ Bilateral ☐ N/A	
Select where applicable		
Prior Biopsy	☐ R ☐ L ☐ Bilateral	
Prior Lumpectomy	☐ R ☐ L ☐ Bilateral	
Prior Mastectomy	☐ R ☐ L ☐ Bilateral	
Recent Cyst Aspiration	☐ R ☐ L ☐ Bilateral	
Breastfeeding	☐ Yes ☐ No	
Previous Examination	☐ Yes ☐ No	

BONE MINERAL DENSITOMETRY (BMD) ☐ Baseline/Low Risk ☐ High Risk

Height: _____ ft'in or _____cm	Weight: _____ lbs or _____ Kg
BMI: _____ kg/m^2 (if known)	

Patient Risk Factor Screening

☐ Please confirm that the Patient has had no Barium Tests or Nuclear Scans in the past 10 days

Has the patient been treated with medicine for osteoporosis?	Yes	No
Is the patient currently on any steroid medication?	Yes	No
Family history of osteoporosis?	Yes	No
History of fracture after age 40?	Yes	No
History of back or hip surgery?	Yes	No

OBSTETRICAL ULTRASOUND ☐ Urgent

Indicate LMP: MM/DD/YY _____/_____/_____
Indicate EDC: MM/DD/YY _____/_____/_____
Please Specify:
☐ Singleton ☐ Twin
☐ Multiple ☐ Unknown
☐ Dating
☐ EFTS 11w to 13w 6d *
☐ Anatomy
☐ BPP
☐ Other, please specify:_____

** Patient must bring lab/blood requisition with them to the appointment*

GENERAL ULTRASOUND ☐ Urgent

Patient Weight Weight: _____ lbs or _____ Kgs

Abdomen/Pelvis	Vascular	Miscellaneous
☐ Upper Abdomen	☐ Carotid Doppler	☐ Thyroid
☐ Upper Abdomen incl Portal/Hepatic Doppler	☐ R ☐ L Arm Venous Doppler	☐ Neck/Salivary Gland
☐ Aorta for AAA Screening	☐ R ☐ L Leg Venous Doppler	☐ Testicles/Scrotum
☐ Renal Imaging Study		☐ Soft Tissue Lump
☐ Kidneys Only	**Gynecological**	☐ R ☐ L Groin
☐ Bladder incl Pre and Post Void	☐ Pelvic	☐ R ☐ L Axilla
☐ Prostate incl Pre and Post Void	☐ Transvaginal	☐ Other : Specify _____
☐ Appendix	☐ Sonohysterogram	