Listowel Memorial Hospital
Breast Assessment Centre
255 Elizabeth St E Listowel ON N4W 2P5
Tel: 519-292-2071
Fax: 519-291-2813

Breast Assessment Request Form

Please complete all sections and fax *to 519-291-2813*

1. DATE: _____/_____/_____
Day Month Year

2. Patient Information-

Please use patient label or complete:

Last Name:_____

First Name:_____

Date of Birth: _____/_____/_____
Day Month Year

Health Card No:_____ VC:_____

Address:_____ City:_____

Postal Code:_____ Contact #:_____

Interpreter required ☐ No ☐ Yes, Language_____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Mechanical lift

3. Referring Physician Information

Ref. Physician Name:_____

Address:_____ City:_____

Billing No:_____ Tel.:_____

Fax NO:_____

Family Physician:_____

#

4. Previous Imaging ☐ No ☐ Yes

When? Where?_____

(please attach reports, and send imaging)

**** Screening for patients 40 years to 74 years with no symptoms or previous breast Cancer: patient to call Listowel OBSP 519-291-5490**

5. Reason for Referral

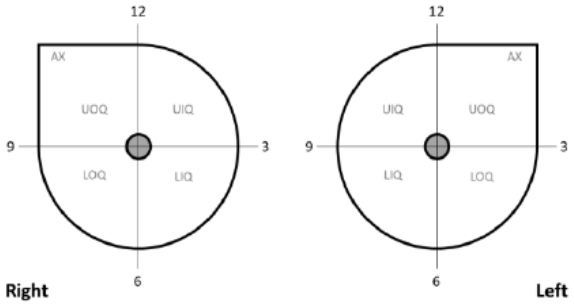
Appointment for:

☐ **Bi-RADS 3**

☐ **Diagnostic**

New Clinical Concern: ☐ No ☐ Yes

Please indicate all clinical concerns on diagram



6. History/Clinical Findings * Required

Does the patient have **breast implants** ☐ No ☐ Yes

Is the patient **pregnant** or **breastfeeding** ☐ No ☐ Yes

Palpable Lump ☐ Right ☐ Left

Lump detected by: ☐ Patient ☐ Physician

Pain ☐ Right ☐ Left

☐ Focal ☐ Diffuse ☐ Intermittent

Nipple Discharge ☐ Right ☐ Left

Type of discharge: ☐ Clear ☐ Bloody ☐ Other

History/Findings:_____

_____

_____

_____

****Note: By signing this requisition, you are providing authorization to the Listowel Memorial hospital to order additional imaging for your patient if required, to resolve this diagnostic request.**

Physician Signature: _____

Listowel use only:

Protocol:_____

Exam Date:_____