



Ontario Breast Screening Program  
**South East Regional Cancer Program**  
 In partnership with Cancer Care Ontario

Phone Number: 613-345-5645 Ext 51120  
 Self- Referral Program for Women 50 - 74  
 75 Charles Street, Brockville, ON K6V 1S8  
[www.cancercare.on.ca/obsp](http://www.cancercare.on.ca/obsp)



Brockville  
 General Hospital

**Diagnostic & BGH Screening  
 MAMMOGRAPHY REQUISITION**  
**PLEASE FAX COMPLETED REQ TO 613-345-8324**  
 As of June 2021

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Health Card #: \_\_\_\_\_ VC: \_\_\_\_\_

**Screening Exam?** Yes  No

**Clinical Information:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Has patient had:**

Previous Mammogram? Yes  No  Where? \_\_\_\_\_ When? \_\_\_\_\_

Previous breast surgery? Yes  No  Findings: \_\_\_\_\_

Implants? Yes  No  Mastectomy? Yes  No

Radiation treatment? Yes  No  When? \_\_\_\_\_

Cancer? Yes  No

Family members diagnosed with breast/ovarian cancer? Yes  No  Who? \_\_\_\_\_

Any benign (non-cancerous) disease of breasts? Yes  No

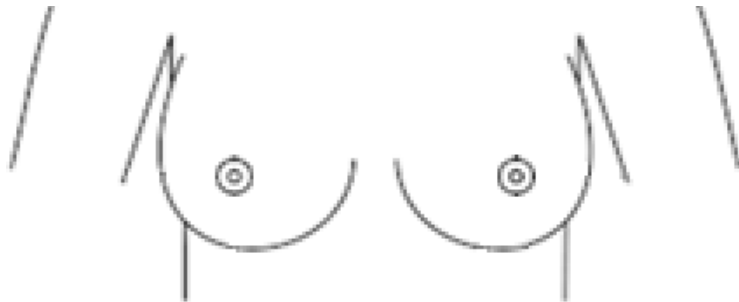
Have you ever been Pregnant? Yes  No  Age when gave birth to first child? \_\_\_\_\_

On hormone replacement therapy? Yes  No  Since when? \_\_\_\_\_

Age of first menstrual period? \_\_\_\_\_ Date of last menstrual period? \_\_\_\_\_

**After completing the requisition, please print and mark any areas of concern:**

The Technologist will indicate any scars, Skin lesions or inverted nipples.



Right side

Left Side

**Ordering Provider Name:** \_\_\_\_\_ (Please print)

**Ordering Provider Signature:** \_\_\_\_\_ (**Print and sign**) **Date:** \_\_\_\_\_

**Booking Office Use:**

Date: _____	Time: _____	Confirmed: _____
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