Brockville General Hospital

DIAGNOSTIC AND SCREENING MAMMOGRAPHY REQUISITION

PLEASE FAX COMPLETED REQ TO (855) 564-1827

As of August 2025

PATIENT INFORMATION

Last Name	First Name	Date of Birth	YYYY	MM	DD

Address	City	Postal Code

Phone	E-mail Address	Health Card Number	Ver Code

☐ Screening Mammogram ☐ Diagnostic Mammogram

Clinical information

Previous Mammogram? ☐ Y ☐ N

Where? _____

When? _____

Previous breast surgery? ☐ Y ☐ N

Findings? _____

Implants? ☐ Y ☐ N

Mastectomy? ☐ Y ☐ N

Radiation treatment? ☐ Y ☐ N

When? _____

Cancer? ☐ Y ☐ N

Family members diagnosed with breast/ovarian cancer? ☐ Y ☐ N

Who? _____

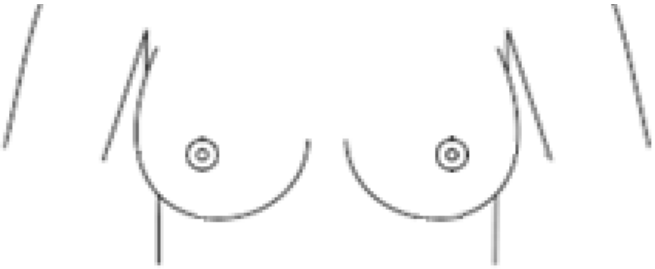
Any benign (non-cancerous) disease of breasts? ☐ Y ☐ N

Ever been pregnant? ☐ Y ☐ N

Age at which you gave birth to first child? _____

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**

Age of first menstrual period? _____

Date of last menstrual period? _____

On hormone replacement therapy? ☐ Y ☐ N

Since when? _____

CLINICIAN INFORMATION

Date of the Request (YYYY/MM/DD): _____/____/____

Requesting Clinician Name (PRINT First and Last Name)	Clinician Fax Number

Clinician Signature	Clinician Phone Number

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

Copy Report to (PRINT First and Last Name)	Copy to Fax Number

DIAGNOSTIC IMAGING USE ONLY

Date (YYYY/MM/DD): _____/____/____ Time: _____ Confirmed: _____