Brockville General Hospital

Diagnostic & BGH Screening
MAMMOGRAPHY REQUISITION

PLEASE FAX COMPLETED REQ TO 613-345-8324

As of December 2022

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 ☐

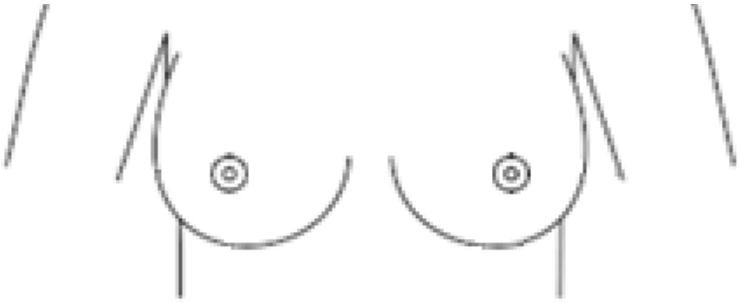
Have you ever been Pregnant? Yes ☐ No ☐ Age when gave birth to first child? _____

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:** _____