Trillium Health Partners
Better Together

Diagnostic Imaging Requisition: Breast Imaging

PATIENT DEMOGRAPHICS:

Last Name: ______________________ First Name: ______________________________ Date of Birth (DD/MM/YYYY): _____/_____/______

Health Card #: ____________________________________ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: ______________________________________ City: ________________ Province: _____________ Postal Code: ____________

Telephone number: _________________________ Mobile number: ____________________ Email Address: _________________________

Mobility Status ☐ Ambulatory ☐ Assist w help ☐ Non-Ambulatory ☐ Assistive Device ☐ Wheelchair

Clinical Indication/Reason for Exam/Clinical History

Diagnostic Imaging Examinations Requested

Mammogram	☐ Right	☐ Left	☐ Bilateral	☐ Screening (OBSP)	☐ Implants
Breast Ultrasound (not for screening)	☐ Right	☐ Left	☐ Bilateral		
Ductogram	☐ Right	☐ Left	☐ Bilateral		
Ultrasound Breast Biopsy	☐ Right	☐ Left	☐ Bilateral	☐ 1 site	☐ 2+ sites
Stereotactic Breast Biopsy	☐ Right	☐ Left	☐ Bilateral	☐ 1 site	☐ 2+ sites
Breast Localization	☐ Right	☐ Left	☐ Bilateral	☐ 1 site	☐ 2+ sites

Other: ____

By signing this requisition, you are providing authorization to Trillium Health Partners for this patient to receive additional breast imaging exams, procedures and surgical (Diagnostic Assessment Program) consult, as required to resolve this request.

ALL previous breast imaging reports AND images MUST be sent for this appointment (if previous available).

To enrol your patients in the High Risk Ontario Breast Screening Program please complete the HR OBSP requisition form on Cancer Care Ontario Website https://www.cancercareontario.ca/obsphighrisk

Present Complaint

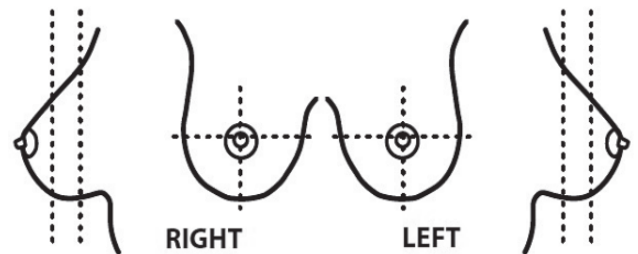
☐ Palpable Lump
☐ Personal History of Breast Cancer
☐ Abnormal Screening Mammogram
☐ Dimpling and/or Contour Deformity
☐ Follow-up Previous Findings
☐ Localized Pain/Tenderness
☐ Nipple Discharge
☐ Thickening

Specify: ____

☐ Other

Specify: ____

Mark All Areas of Concern



REFERRING PROVIDER:

Name of Referring Provider (Last Name, First Name- as listed in CPSO): ____

Address: ______________________________ City: ____________________ Province: _____________ Postal Code: ______________

Phone number: __________________ Fax number: _______________ CPSO #: ______________ Billing (OHIP) #: ________________

Signature: _______________________________________ Date: ___________________

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Mississauga Hospital 100 Queensway W, Mississauga, ON, L5B 1B8 Phone: 416-521-4069 Fax: 416-521-4014
Queensway Health Centre 150 Sherway Drive, Etobicoke, ON, M9C 1A5 Phone: 416-521-4069 Fax: 416-521-4014