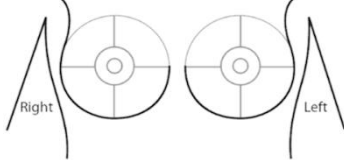


**MAMMO-BMD ULTRASOUND REQUISITION
FOR OUTPATIENT REFERRAL**

PATIENT LABEL

Clinical History/Indication			
Reason for exam			
Patient Name:	DOB: (dd/mm/yyyy)	OHIP #:	VC:
Address:		Phone:	
Referring Physician: (print)	Phone:	Fax:	
Physician's Signature:		Date of Referral: (dd/mm/yyyy)	

BREAST IMAGING		
Mammography	Ultrasound	Interventional (includes Consul)
<input type="checkbox"/> Diagnostic Mammography	<input type="checkbox"/> R <input type="checkbox"/> L Breast Ultrasound	<input type="checkbox"/> R <input type="checkbox"/> L Ultrasound Guided Biopsy
<input type="checkbox"/> Screening Mammography (OBSP)		<input type="checkbox"/> R <input type="checkbox"/> L Ultrasound Guided Needle Localization
<input type="checkbox"/> Screening Mammography (Non-OBSP)		
Patient Screening		
Breast Implants	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> N/A	Please indicate findings on diagram: 
Prior Breast Ca	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> N/A	
Symptomatic	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral <input type="checkbox"/> N/A	
<i>Select where applicable</i>		
Prior Biopsy	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral	
Prior Lumpectomy	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral	
Prior Mastectomy	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral	
Recent Cyst Aspiration	<input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bilateral	
Breastfeeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No	

BONE MINERAL DENSITOMETRY (BMD) <input type="checkbox"/> Baseline/Low Risk <input type="checkbox"/> High Risk	
Height: _____ ft/in or _____ cm	Weight: _____ lbs or _____ Kg
BMI: _____ kg/m ² (if known)	
Patient Risk Factor Screening	
<input type="checkbox"/> Please confirm that the Patient has had no Barium Tests or Nuclear Scans in the past 10 days	
Has the patient been treated with medicine for osteoporosis?	Yes No
Is the patient currently on any steroid medication?	Yes No
Family history of osteoporosis?	Yes No
History of fracture after age 40?	Yes No
History of back or hip surgery?	Yes No

OBSTETRICAL ULTRASOUND <input type="checkbox"/> Urgent
Indicate LMP: MM/DD/YY _____/_____/_____
Indicate EDC: MM/DD/YY _____/_____/_____
Please Specify:
<input type="checkbox"/> Singleton <input type="checkbox"/> Twin
<input type="checkbox"/> Multiple <input type="checkbox"/> Unknown
<input type="checkbox"/> Dating
<input type="checkbox"/> EFTS 11w to 13w 6d *
<input type="checkbox"/> Anatomy
<input type="checkbox"/> BPP
<input type="checkbox"/> Other, please specify: _____
<i>* Patient must bring lab/blood requisition with them to the appointment</i>

GENERAL ULTRASOUND <input type="checkbox"/> Urgent		
Patient Weight Weight: _____ lbs or _____ Kgs		
Abdomen/Pelvis	Vascular	Miscellaneous
<input type="checkbox"/> Upper Abdomen	<input type="checkbox"/> Carotid Doppler	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Upper Abdomen incl Portal/Hepatic Doppler	<input type="checkbox"/> R <input type="checkbox"/> L Arm Venous Doppler	<input type="checkbox"/> Neck/Salivary Gland
<input type="checkbox"/> Aorta for AAA Screening	<input type="checkbox"/> R <input type="checkbox"/> L Leg Venous Doppler	<input type="checkbox"/> Testicles/Scrotum
<input type="checkbox"/> Renal Imaging Study		<input type="checkbox"/> Soft Tissue Lump
<input type="checkbox"/> Kidneys Only	Gynecological	<input type="checkbox"/> R <input type="checkbox"/> L Groin
<input type="checkbox"/> Bladder incl Pre and Post Void	<input type="checkbox"/> Pelvic	<input type="checkbox"/> R <input type="checkbox"/> L Axilla
<input type="checkbox"/> Prostate incl Pre and Post Void	<input type="checkbox"/> Transvaginal	<input type="checkbox"/> Other : Specify _____
<input type="checkbox"/> Appendix	<input type="checkbox"/> Sonohysterogram	

