# REQUEST FOR BREAST ASSESSMENT/BMD

Strathroy Middlesex General Hospital Breast Assessment Program
395 Carrie St. Strathroy, Ontario N7G 3J4

| | |
|---|---|
| Patient Last Name ______________ | First Name ______________ |
| Address ______________ | |
| Health Card # ______________ | Date of Birth YY MM DD ______________ |
| Phone #1 ______________ | Phone #2 ______________ |

FOR APPOINTMENTS CALL
TEL: 519-246-5200
BETWEEN 8:30 AM - 4:00 PM
FAX: 519-245-3843

______________
APPOINTMENT DATE

______________ ☐ AM ☐ PM
TIME

IMPORTANT: Please bring your health card. No children allowed in the exam room during an exam, please arrange child care.

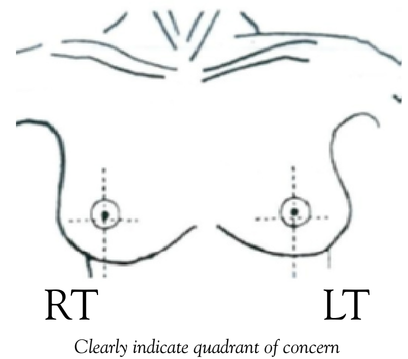
PATIENTS:
For Breast Imaging: Please wear a 2 piece outfit and no deodorant.
For BMD: Wear elastic waistband and no calcium supplement 24 hours prior.

## BREAST IMAGING (By Appointment)

☐ ROUTINE SCREENING: ☐ BILATERAL ☐ RIGHT ☐ LEFT

☐ DIAGNOSTIC : DESCRIBE AREA OF INTEREST

RELEVANT HISTORY/CLINICAL FINDINGS:




*Clearly indicate quadrant of concern*

## PLEASE COMPLETE FOR BREAST ASSESSMENT

IMPLANTS ☐ YES

Special Needs ______________
*Please indicate if physical/ cognitive challenges/ nursing home patient*

Previous Breast Imaging ☐ NO ☐ YES

When______________

Where______________

## BONE MINERAL DENSITOMETRY

*Patient must be >18 yrs old, Weight limit 300lbs.*

☐ Repeat Previous:
When______________
Where ______________

☐ Baseline - No Previous

*(Note: Booking interval for high risk 1 year + 1 day)*

*Required information for radiologist:*
Treatment for Bone Loss?:
Drug: ______________
Start Date: ______________

Corticosteroid Treatment >3 months?
Start Date: ______________

Fragility Fracture after 40? ☐ NO ☐ YES

## PHYSICIAN AUTHORIZATION

By signing this requisition, you are providing authorization to SMGH for your patient to receive additional imaging (mammography, ultrasound and procedures as triaged by the breast radiologist) to resolve this diagnostic request. This authorization does not include any imaging or procedures which may be required at another facility.

| | | | |
|---|---|---|---|
| Referring Dr/ NP Signature | Family Dr. Signature | DATE (YYYY/MM/DD) | COPY To: |

*SMGH Bookings will contact patient directly to arrange appointments. The requesting physician will receive notification of booking.*