MEDRAY IMAGING

Breast Imaging Requisition

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www.medrayimaging.com

Patient: PHN: Bill to: ☐MSP ☐SELF ☐OTHER

DOB: Gender: ☐F ☐M ☐U Patient Phone #:

Physician: Billing# Signature:

Physician address: Physician fax #:

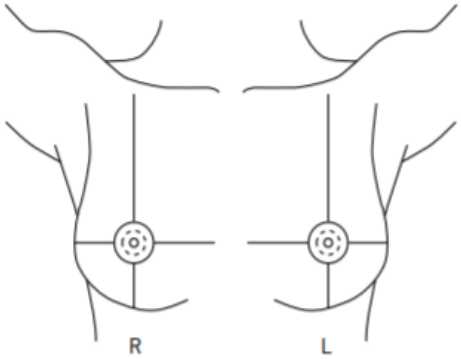
Copies to Name & Fax #:

Patient History and Indication (*followed by our radiologist recommendations for imaging*)

Previous mammograms/biopsy (when& where)

Is patient pregnant? ☐ yes* ☐ no Is patient breastfeeding? ☐ yes* ☐no (*mammography is usually not recommended)

Mark area(s) of concern



Diagnostic Indication (Must be checked)

☐ **Lump** (mammography and targeted ultrasound) **

☐ **Thickening** (mammography and targeted ultrasound) **

☐ **Nipple discharge** (mammography and targeted ultrasound) **

☐ **Previous breast cancer** (annual mammography only) **

☐ **Previous breast cancer with total mastectomy** (targeted ultrasound of area of concern)

☐ **Localized pain/ tenderness** (Age 35 + mammography only. Patients under 35 targeted ultrasound)

☐ **Breast prothesis (implants) for screening** (annual mammography for patients age 40+)

☐ **Breast prosthesis (implants) for complaint**- choose one of the indications above

☐ **Male for gynecomastia** (mammography and bilateral breast ultrasound age 25+)

☐ **Follow- up previous findings** (As per reported recommendations)

☐ **Other** (specify): _____

** Mammography is usually not recommended for patients under 30. Patients age 30-35 may require mammography if further workup is required.

We require breast imaging requisitions be faxed to 604-942-4612. Incomplete requisitions will be rejected and returned.