Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital
Partnering to keep healthcare close to home.

BREAST IMAGING REQUISITION

Tillsonburg District Memorial Hospital (TDMH)
TDMH Scheduling/Bookings Contact:
Phone: 519-842-6335 Fax: 519-842-4299

Referring Physician or Other Authorized Health Care Provider

Name (Please Print): _____

Phone:_____Fax:_____

Provider Billing #:_____

Provider Signature: _____

Copy to:_____

Date of Referral: _____
(YYYY/MM/DD)

**By signing this requisition you are providing authorization for your patient to receive additional imaging (Mammography, Ultrasound, and other procedures) as deemed necessary by the responsible Radiologist to resolve this diagnostic request.

Patient Information:

Name (Last, First): _____

Date of Birth (DOB) : (YYYY/MM/DD) _____

Personal Identification Number (PIN): _____

Address: _____

Phone Number (Home): _____

(Other): _____

Health Card Number:_____ Version Code: _____

Does this patient have?

Previous Breast Imaging: ☐ No ☐ Yes

When: _____

Where: _____

Previous Breast Cancer: ☐ No ☐ Yes

Mastectomy: ☐ Right ☐ Left

Implants: ☐ No ☐ Yes

Special needs or impairments, specify:_____

**Patients 40-74 with no history of breast cancer or current breast concerns will be part of the Ontario Breast Screening Program.

Examination (s) Requested:

MAMMOGRAM

☐ Routine Screening Mammogram (Asymptomatic)
☐ OBSP Screening Mammogram (Asymptomatic)
☐ Diagnostic Mammogram (Symptomatic)

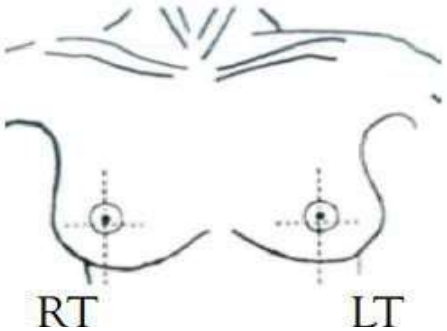
☐ Right (RT) ☐ Left (LT)

ULTRASOUND (US)

☐ RT Breast ☐ RT Axilla
☐ LT Breast ☐ LT Axilla
☐ Bilateral Breast
☐ Bilateral Axilla

US Guided Procedures

☐ Biopsy ☐ RT ☐ LT ☐ Bilateral
☐ Aspiration ☐ RT ☐ LT ☐ Bilateral
☐ Localization ☐ RT ☐ LT ☐ Bilateral



Clearly Indicate Quadrant of Concern with an "X"

1) Pain? ☐ No ☐ Yes , specify area _____
☐ focal or ☐ diffuse

2) Lump felt?
☐ By patient
☐ By Physician, specify location _____

3) Other, please specify:
_____

4) If the patient is over 70 yrs old please include Creatinine within 6 months in case a Contrast mammogram is required: _____
Date: (YYYY/MM/DD) _____

CLINICAL HISTORY

UNSIGNED, INCOMPLETE REQUISITIONS WILL BE RETURNED AND APPOINTMENTS WILL NOT BE BOOKED UNTIL A SIGNED AND COMPLETED REQUISITION IS RECEIVED.