CHESTERMERE XRAY & MAMMOGRAPHY

RadiologyAssociates

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PATIENT

NAME: (LAST) (FIRST) (MIDDLE) ☐ AHC#: ☐ WCB#:

ADDRESS: CITY: ☐ OUT OF PROVINCE#:

POSTAL CODE: PROVINCE: AGE: DOB: (MM / DD / YEAR) LMP: (MM / DD / YEAR)

PHONE #: HOME WORK / CELL ☐ MALE ☐ FEMALE PREGNANT: ☐ YES ☐ NO

REFERRAL

ORDERING PHYSICIAN: SEND COPY TO:

ORDERING PRAC ID: CLINIC NAME:

CLINIC NAME: PHONE #:

PHONE #: FAX #: FAX REPORTS TO #:

HISTORY & PROVISIONAL DIAGNOSIS:

☐ Wheelchair, walker, limited mobility, etc. (allow more time)

☐ Relevant prior imaging: _____ (LOCATION AND DATE OF EXAM)

*Discretion to modify order as per Radiologist _____ M.D.

EXAM

BREAST IMAGING HISTORY AND PREPARATION

☐ IMPLANTS (requires more time)

☐ PREVIOUS BREAST CANCER

On the day of the exam, wash off all deodorants, perfumes, powders and/or lotions under the arm and across the chest.

☐ **SCREENING MAMMOGRAM**

☐ BILATERAL ☐ LEFT ☐ RIGHT

☐ **X-RAY** (No preparation required)

BODY PART: _____

BRING VALID HEALTH CARE CARD & THIS FORM. If you are unable to attend your appointment, please call to cancel or reschedule at least 2 hours prior to your appointment. NO SHOWS MAY BE CHARGED. CHILDREN ARE NOT ALLOWED IN EXAM ROOMS. CHILD CARE IS NOT PROVIDED.