



DATE _____ HRN _____
 PATIENT _____
 DOB _____
 PROV HC# _____
 DOCTOR _____
 CLINIC/UNIT _____ LOC'N _____

Supplemental Form for Breast Imaging

Part 2

REQUEST FOR CONSULTATION BREAST ULTRASOUND

PATIENT INFORMATION

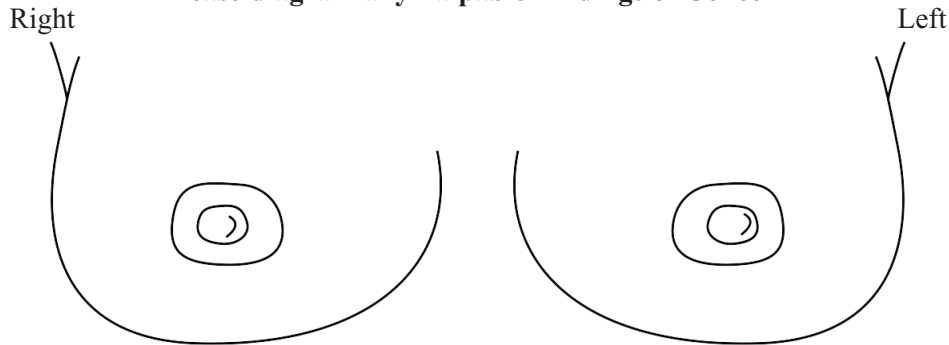
Patient Name (Last/First) _____
 PHIN _____ Sex Male Female
 Address _____ City _____
 Province _____ Postal Code _____
 Phone Home () _____ Work () _____
 Cell () _____ Maiden Name _____
 DOB (mm/dd/yy) _____

PREVIOUS RELEVANT BREAST IMAGING STUDIES INCLUDING DATE (Please fax copy of report with requisition)

	MAMMOGRAM	ULTRASOUND	MRI
Health Sciences Centre <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WRHA Breast Health Centre <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manitoba Breast Screening Program <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manitoba X-ray Clinic <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiology Consultants <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
St. Boniface General Hospital <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grace Hospital <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Misericordia Hospital <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Previous <i>Date:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Exam

Please diagram any Palpable Findings of Concern



AUTHORIZED CLINICIAN INFORMATION

Signature (Print and Sign) _____ MHSC Billing # _____
 Address _____ Phone # _____ Fax # _____ Date _____
 Extra Report To: _____
 Name/Address/Phone _____ Fax # _____

Office Use Only Coding _____

Appointment Date/Time _____