FREEPORT HEALTH CENTRE
3570 King Street East
Kitchener, ON N2A 2W1
Phone: (519) 749-4270
Fax: (519) 894-8328

Waterloo Wellington BREAST CENTRE

GRAND RIVER HOSPITAL
your health, your hospital

*Referring Physician Name:	*Patient Name: (Last, First)
Phone #: Fax #:	*DOB: (Y/M/D) HC#:
*Physician Signature:	*Pt. Consented Contact Phone # Patient has consented for a message to be left at this number? ☐ Yes ☐ No

Exam Requested

☐ ontario breast screening program — a cancer care ontario program

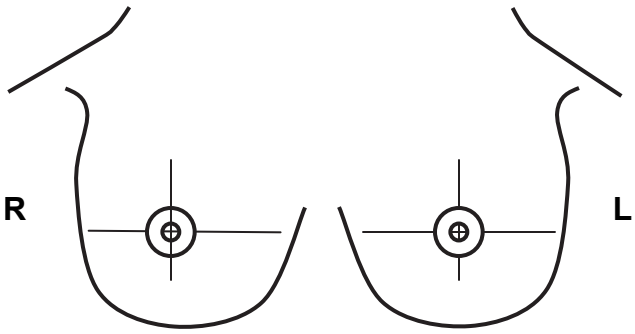
OR

☐ **Bilateral Mammogram**

☐ **Breast Ultrasound** ☐ **R** ☐ **L**

*Relevant Clinical History and diagram below must be completed	*Office Use only* Appt Time
☐ Previous breast CA ☐ Breast implants ☐ Previous breast surgery	

BREAST ASSESSMENT OR INTERVENTIONAL REQUEST



☐ Breast Assessment Clinic*

(Includes Surgical Consult)

☐ Woman **over 40 yrs** of age with <u>either</u> a new palpable mass OR previous abnormal imaging. *(imaging report must be faxed with requisition)*

☐ Woman **under 40 yrs** of age with a palpable abnormality <u>and</u> abnormal imaging.

Complete diagram and check boxes above to reflect clinical findings

Interventional Request *(Includes Radiologist Consult)*

☐ Ultrasound Guided Biopsy ☐R ☐L ☐ Aspiration ☐R ☐L

☐ Stereotactic Core Biopsy ☐R ☐L ☐ Needle Wire Localization ☐R ☐L

Patient on Anticoagulants ☐Y ☐N Type & Dose:_____

(*) Indicates areas which must be completed or requisition will be returned