505-750 West Broadway | Vancouver, BC V5Z 1 H4
T: 604-879-4177 | F: 604-879-4147

Mammography Requisition

FIRST NAME	SURNAME	
ADDRESS	DATE OF BIRTH (MM/DD/YY)	
CELL PHONE	HOME PHONE	
PERSONAL HEALTHCARE # (PHN)	PAYMENT INFORMATION □ MSP □ ICBC □ WCB □ OTHER CLAIM #: _____	

Appointment Date: _____ **Time**: _____

EXAMINATION REQUESTED
Please check indication(s) for mammogram:

- ☐ Lump, thickening, nodularity, deformity, serious or sanguineous nipple discharge, non-cyclical localized pain or tenderness
- ☐ Follow up prior CA
- ☐ Search for unknown primary malignancy
- ☐ Suspected complications of breast implants
- ☐ First post-operative mammogram following a benign biopsy
- ☐ Work up of patient after abnormal screening mammogram
- ☐ Patient under 40 with very strong family history of breast cancer
- ☐ Patient with breast implants
- ☐ Services provided by SMPBC are not available or cannot be reasonably accessed
- ☐ Other, specify:

PREVIOUS MAMMOGRAM

Date: _____

Location: _____

Number: _____

PRIORITY
□ Routine
□ Urgent
□ Stat

ORDERING PHYSICIAN	BILLING #	DATE
SIGNATURE OF ORDERING PHYSICIAN		CC REPORT TO