Alberta Health Services

Mammography Request

- ALL fields must be completed in order to process request
- Fax to Diagnostic Imaging; fax numbers listed at http://www.albertahealthservices.ca/diagnosticimaging
  Urgent/Emergent requests must be discussed by direct consultation with a radiologist

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Preferred Facility		Inpatient Location
Patient Phone Number *(Cell # preferred)*		Patient Address
City	Postal Code	WCB Claim Number
Ordering Provider Name	Provider ID	Department ID
Provider Fax	Provider Phone	Contact Number for Critical Test Results
Provider Address/Location	City	Postal Code

Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____

Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and middle)*	Copy to Fax

STAT report requested ☐ No ☐ Yes, if yes ► Specify phone/ pager

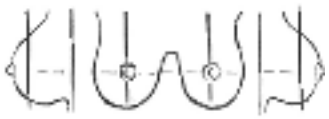
Reason for Exam

Clinical question to be answered

☐ Screening *(Note: addition of supplemental imaging will be determined at the time of screening)*

☐ Diagnostic *(please check the appropriate boxes below for each breast and indicate on the diagram)*

Pain ☐ Right ☐ Left ☐ Both
Lump ☐ Right ☐ Left ☐ Both
Discharge ☐ No ☐ Right ☐ Left ☐ Both Type of discharge _____



Additional Information (please describe)

☐ Interventional *(please check the appropriate boxes below, describe it and indicate on the diagram)*

☐ Right ☐ Left ☐ Both ► ☐ Aspiration ☐ Core Biopsy ☐ Localization ☐ Mammoductography
On Anticoagulants ☐ No ☐ Yes ► Specify _____
Additional Information

Relevant clinical history/presumptive diagnosis	✓ No	✓ Yes ►	Describe
First degree relatives with breast cancer before age 50?	☐	☐ ►	_____
Previous breast cancer?	☐	☐ ►	_____
Previous biopsy?	☐	☐ ►	_____
Previous surgery?	☐	☐ ►	_____
Implants?	☐	☐ ►	_____

Relevant Previous Imaging Studies *(Mandatory)*

Modality	Location	Date *(dd-Mon-yyyy)*	Attach copy ☐ No ☐ Yes

Current Patient Condition

Patient pregnant ☐ No ☐ Yes ► LMP: _____ Beta HCG: _____

Transportation ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Oxygen
Patient Type ☐ Outpatient ☐ Emergency ☐ Inpatient ► ☐ Patient Location _____

Department Use Only

Date Received *(dd-Mon-yyyy)*	Time Received *(hh:mm)*	Date of Appointment *(dd-Mon-yyyy)*	Time of Appointment *(hh:mm)*