nova scotia health

DIAGNOSTIC MAMMOGRAPHY CONSULTATION REQUEST

Toll Free Fax #: 1 - 866 - 470 - 3959

IWK Health

PROVIDER TO COMPLETE

APPOINTMENT SITE REQUESTED

☐ Amherst ☐ Antigonish ☐ Bridgewater ☐ Dartmouth ☐ Halifax

☐ Kentville ☐ New Glasgow ☐ Sydney ☐ Truro ☐ Yarmouth

PATIENT INFORMATION

Health Card # ____________ DOB: YYYY / MM / DD ____________

Surname First Name Middle Inital ____________ Telephone # ____________

Name (Used) Pronouns Sex at Birth Gender Identity ____________

Address City Postal Code ____________

Email ____________ WCB # (If applicable) ____________

Mode of Transportation: ☐ Ambulatory ☐ Stretcher ☐ Wheelchair

Fall Risk?: ☐ Yes ☐ No

Isolation Precautions: ☐ Droplet ☐ Contact ☐ Airborne

PATIENT IDENTIFICATION (*For Internal Use Only*)

REQUESTING PROVIDER: (*Please Print*)

Provider Name: ____________

Provider Number: ____________

Contact / Fax #: ____________

Signature: ____________

Date Signed: ____________

COPIES TO: ____________

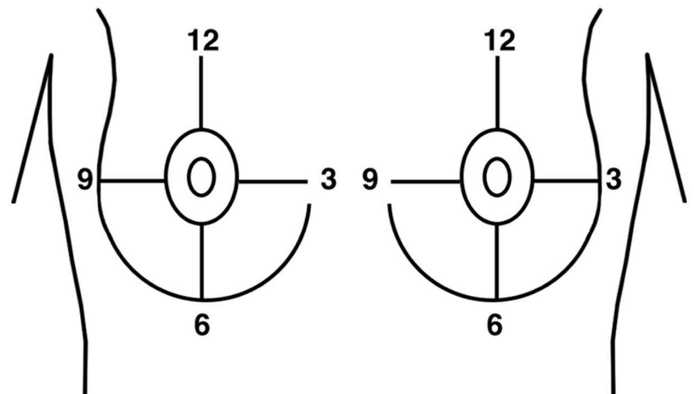
EXAMINATION REQUESTED

☐ Diagnostic Mammogram ☐ Breast Ultrasound ☐ Core Biopsy ☐ Pre-operative Localization

☐ Other Examination (*specify*): ____________

☐ Urgent ☐ Semi-Urgent ☐ Routine

HISTORY AND CLINICAL INFORMATION



Indicate: ☐ Right ☐ Left

Does the patient have breast implants?: ☐ Yes ☐ No

SYMPTOMATIC (CHECK WHERE APPROPRIATE):

☐ Palpable Lump/Thickening
☐ Nipple Scaling/Rash
☐ Nipple Retraction
☐ Focal Pain
☐ Axillary Adenopathy
☐ Skin Dimpling