Hamilton Health Sciences

JURAVINSKI SITE

BREAST MR CONSULT
(A completed MRI Requisition **MUST** be submitted with this form)

711 Concession Street
Hamilton, ON L8V 1C3
Ph # 905-577-1484 / Fax # 905-387-8813

Affix Patient Label here

INDICATION FOR REFERRAL (check one)

☐ OBSP High Risk Screening (confirmed with genetic assessment)

☐ Prior radiation. Please indicate dose _____

☐ Diagnostic Assessment (ordered by radiologist)

☐ Pre-Operative Staging

☐ Other: _____

PREVIOUS BREAST IMAGING (Mammogram, Ultrasound, MRI)

❑ All previous at HHS / SJH (detailed history to be provided on MR requisition)

❑ Non HHS imaging. Please provide details as below:

1. Mammo Location and Date: _____
2. Ultrasound Location and Date: _____
3. Other MR/CT Location and Date: _____
4. Provide details of any surgery or biopsy: _____

For all Community and non HHS referrals, please attach all relevant reports (Including surgical notes, previous imaging and pathology)

Please Note: Breast MR cannot be booked until previous imaging is available on our PACS system.