711 Concession Street
Hamilton, ON L8V 1C3
PLEASE FAX TO: 905-381-7084

*PLEASE INCLUDE
PATIENT DEMOGRAPHICS HERE*

BREAST MR CONSULT

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

INDICATION FOR REFERRAL (CHECK ONE)

- ☐ OBSP High Risk Screening (confirmed with genetic assessment)
- ☐ Diagnostic Assessment (recommended by JH radiologist report)
- ☐ 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 below:

1. Mammography location and date: ______________________________
2. Ultrasound location and date: ______________________________
3. Other MR/CT location and date: ______________________________
4. Provide details of any breast surgery or biopsy: ______________________

ATTACHMENTS

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

☐ Number of attached reports: ______________________________

PLEASE NOTE: BREAST MR CANNOT BE BOOKED UNTIL PREVIOUS IMAGING HAS BEEN UPLOADED INTO OUR SYSTEM.

PATIENT NAVIGATION

By signing this form, you authorize the CIBC Breast Assessment Centre to schedule all recommended diagnostic assessment and follow-up including additional imaging, biopsies and follow-up exams for abnormal results, genetic assessment and referral to next available surgeon.

Please indicate below if you have specific requests regarding patient navigation (eg. specific surgeon):

☐ ____