

DIGITAL MAMMOGRAPHY



ASSOCIATED RADIOLOGISTS LLP
www.saskradiology.ca

TAKE THIS TO: **SOUTH HILL MEDICAL CENTRE**
#15 - 2685 2nd Avenue West
Prince Albert, SK S6V 5E3
Telephone (306) 763-8595
Fax (306) 763-7054

Please bring your Health Card

Your appointment is at _____ on _____
TIME DAY / DATE

THIS FORM MUST BE PRESENTED AT THE TIME OF EXAM

Patient Information:

Mr. Mrs. Ms. _____
PATIENT'S NAME (PLEASE PRINT)

Address: _____ Phone: _____

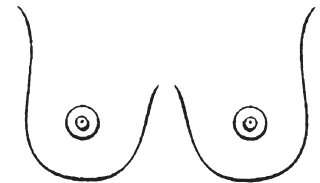
SHSP: _____ Birth Date: _____
NUMBER DAY / MONTH / YEAR

WCB (or other): _____
PAYMENT RESPONSIBILITY (PLEASE PRINT)

- Firm compression of the breasts is required, and this may be uncomfortable momentarily. There is less discomfort if the mammogram is performed during the first 2 weeks of the menstrual cycle.
- **DO NOT WEAR UNDERARM DEODORANT, TALC, OR LOTION.**

EXAMINATION:

PHYSICIAN ONLY:
Clinical Findings



RIGHT

LEFT

CLINICAL HISTORY:

× = MOLE
● = PALPABLE MASS

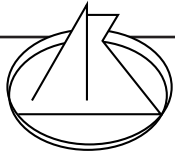
Previous X-Rays; location and date: _____

DOCTOR'S SIGNATURE REQUIRED

BEFORE EXAMINATION WILL BE DONE

DOCTOR'S SIGNATURE

PRINT NAME



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OFFICE HOURS
(Monday - Friday)
8:30 a.m. to 11:55 a.m.
1:00 p.m. to 4:55 p.m.

PATIENT HISTORY:

Date of last menstrual period?

Have you ever been on
Hormone Replacement
Therapy (HRT)?..... Yes No

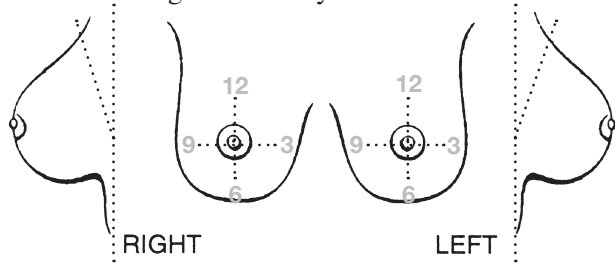
If yes, how many years?

History of breast lumps?..... Yes No

History of nipple discharge?..... Yes No

If yes, what colour?

For Technologist Use Only:



History of breast surgery?..... Yes No

History of treatment for
breast cancer?..... Yes No

Family history for
breast cancer?..... Yes No

Relation?

Have you ever been pregnant? Yes No