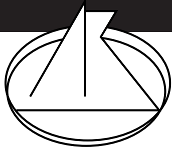
BREAST IMAGING



ASSOCIATED RADIOLOGISTS LLP
www.saskradiology.ca
Canadian Association of Radiologists Accredited since 1995

Your Appointment is

at ____________ on ____________________
TIME DAY / DATE

☐ **Wall Street Medical Building**
300 - 140 Wall Street (3rd Floor)
Saskatoon SK S7K 1N4
Fax (306) 244-1349

Office Hours:
Monday - Friday
8:30 am - 11:55 am (closed from noon - 1:00 pm)
1:00 pm - 4:55 pm
Telephone: (306) 244-1167

THIS FORM MUST BE PRESENTED AT THE TIME OF EXAM

Patient Information:

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

Address: ______________________________ Phone: ______________

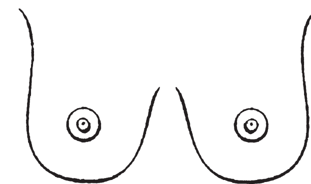
SHSP: ______________________________ Birth Date: ______________
NUMBER DAY / MONTH / YEAR

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

EXAMINATION:

CLINICAL HISTORY:

Clinical Findings



RIGHT LEFT

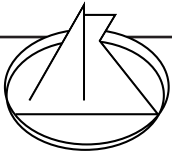
Palpable abnormality? Yes ☐ No ☐
Side .... Right or Left
Location?........................

Family history of breast cancer? Yes ☐ No ☐
Mother/Sister/Daughter

Nipple discharge? Yes ☐ No ☐

Colour?
red / brown / green / creamy / clear

DOCTOR'S SIGNATURE REQUIRED
BEFORE EXAMINATION WILL BE DONE ______________________ ______________
DOCTOR'S SIGNATURE PRINT NAME



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PATIENT HISTORY:

Date of last menstrual period? ....

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

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

If yes, what colour? ....

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

History of breast core bx? .... 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 □

Previous Mammogram, location and date: ______________________________

For Technologist Use Only: