BREAST IMAGING REQUEST

Queensland Government

Royal Brisbane and Women's Hospital
Level 3, Ned Hanlon Building, Herston 4029
Phone: 3646 2606 Fax: (07) 3646 5379

Metro North Hospital and Health Service

UR..... ☐ Female ☐ Male ☐ Indeterminate

Family Name.....

Given Names.....

DOB...../...../.....

Home address.....

Phone Nos.....

☐ Inpatient Ward.....

☐ Outpatient Clinic.....

☐ Bulk Bill (Private Pt)

☐ 12 Months ☐ 6 Months ☐ Within 2 Weeks

☐ Urgent (arrange with Radiologist x 68172)

Date required.....

EXAMINATION REQUESTED

☐ Mammogram / Ultrasound ☐ Ultrasound FNA

☐ Ultrasound only ☐ Ultrasound Core Biopsy

☐ MRI Breast - **reverse side must be completed** ☐ Stereotactic Core Biopsy

On **Warfarin**? ☐ Yes INR.....

Pre-operative Localisation... Indicate whether a) AM / PM Theatre List

☐ Ultrasound pre-op localisation b) Inpatient / Day Surgery

☐ Mammogram pre-op localisation

☐ Stereotactic pre-op localisation

RADIOLOGY FINAL CHECK	**YES**
Patient identification verified	☐
Procedure & consent verified	☐
Correct side & site verified	☐
Correct patient data & side markers	☐

Radiographers/Team Leader

Signature.....

PAST HISTORY of *Breast Disease*

☐ Nil

BENIGN

☐ Fibrocystic change ☐ Fibroadenoma

☐ Other .....

MALIGNANT Stage ..... Grade .....

☐ DCIS ☐ LCIS

☐ Invasive ductal Ca ☐ Invasive lobular CA

☐ Other .....

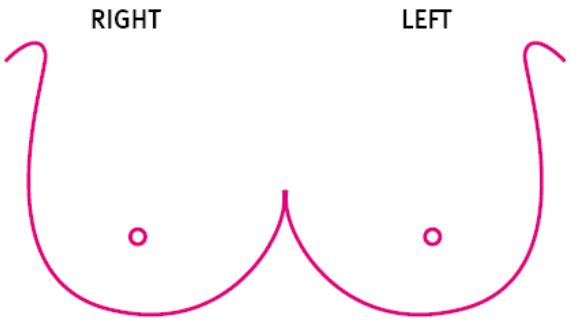
☐ Past Breast Surgery ...../...../.....

☐ WLE ☐ Mastectomy

☐ Axillary Dissection ..... involved lymph nodes

☐ Radiotherapy ☐ Chemotherapy

☐ Hormone Therapy .....



Scars / surgery / biopsy
Acute clinical abnormality

Clinical Details ☐ No clinical concerns. Routine follow-up

or This imaging is needed to (tick one and explain)

☐ Confirm ☐ Exclude ☐ Define ☐ Progress of

Radiologist protocol /Initial.....

Radiographers comments

Requested by ..... Consultant ..... ☐ Bulk Bill

Pager/Phone ..... Provider No. .....

Signature ..... Date .....

Time .....

Date .....

Room .....

Initials .....

Notice to the patient. For Medicare eligible examinations only: Your referrer has recommended that you use Queensland Health. You may choose another provider but please discuss this with your referrer first.

Print Form

MRI BREAST QUESTIONNAIRE

Previous breast imaging? If yes, when?	Mammography - Ultrasound - MRI -
Post menopausal?	
If not, when was the start of their last period?	
Is the patient on Hormone Replacement Therapy? For how long?	
Number of pregnancies?	
Did the patient breastfeed?	
Breast implants? Ever had implants? What are they made of?	
Family history of breast cancer? If yes, who in the family and what age were they at diagnosis?	
Breast surgery? When? What for?	
Radiotherapy to either breast?	
Any lumps, discharge, thickening, or area of concern?	

Obligatory **MRI** questionaire

Aneurysm clip	☐ Yes	☐ No		Programmable shunt	☐ Yes	☐ No	
Embolisation coils	☐ Yes	☐ No		Metal prosthesis	☐ Yes	☐ No	
Inner ear implant	☐ Yes	☐ No		Penetrating eye injury ever	☐ Yes	☐ No	
Neuro/biostimulator	☐ Yes	☐ No		Stent	☐ Yes	☐ No	
Heart surgery	☐ Yes	☐ No		Requires sedation/pain relief	☐ Yes	☐ No	
Prosthetic cardiac valves	☐ Yes	☐ No		Requires GA	☐ Yes	☐ No	
Cardiac pacemaker/wires	☐ Yes	☐ No		Claustrophopbia	☐ Yes	☐ No	
Vena cava filter	☐ Yes	☐ No		Able to lie flat	☐ Yes	☐ No	

Radiographers comments

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Consultant Name .....

Contact Details .....

Phone .....

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