

RADIOLOGY ASSOCIATES OF REGINA MEDICAL P.C. INC.

Drs. Devitt, Verma, Clarke, Rice, Lembke, Suchet, Lim, Hillis, Schulte,
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MAMMOGRAPHY

BREAST ULTRASOUND

Radiology Associates is a scent free workplace. Please refrain from wearing perfumes & cologne on the day of your appointment.

APPOINTMENT DATE: _____ TIME: _____
(please call to confirm appointment)

NAME _____ M D.O.B _____ / _____ / _____
F DD MM YY

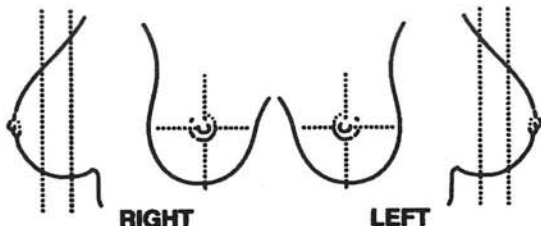
ADDRESS _____

S.H.S.P _____ PHONE# _____

REASON FOR EXAMINATION: (history and clinical please)

- | | |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> PALPABLE LUMP | <input type="checkbox"/> <input type="checkbox"/> NIPPLE DISCHARGE |
| <input type="checkbox"/> <input type="checkbox"/> THICKENING | <input type="checkbox"/> <input type="checkbox"/> ROUTINE HEALTH CHECK |
| <input type="checkbox"/> <input type="checkbox"/> NIPPLE ABNORMALITY | <input type="checkbox"/> <input type="checkbox"/> DIFFUSE NODULARITY |
| <input type="checkbox"/> <input type="checkbox"/> INFLAMMATION | <input type="checkbox"/> <input type="checkbox"/> AXILLARY ADENOPATHY |
| <input type="checkbox"/> <input type="checkbox"/> SKIN CHANGES | <input type="checkbox"/> <input type="checkbox"/> FOLLOW UP |
| <input type="checkbox"/> <input type="checkbox"/> PAIN OR TENDERNESS | <input type="checkbox"/> <input type="checkbox"/> OTHER / (SPECIFY) |

REMEMBER!! INDICATE PREVIOUS MAMMOGRAMS
PREVIOUS MAMMOGRAMS ___ NO ___ YES
DATE _____ **WHERE?** _____
HAS PATIENT BEEN THROUGH BREAST SCREENING
PROGRAM? ___ NO ___ YES



DR _____ CLINIC _____

DOCTOR'S SIGNATURE _____