Breast imaging
Referral

WINDSOR
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PATIENT DETAILS

Patient name: Date of birth:

Address: Phone:

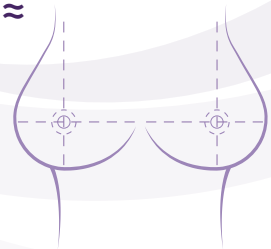
EXAMINATION

☐ Diagnostic assessment
(may include mammogram, ultrasound, biopsy)
☐ Mammogram only
☐ Ultrasound only
☐ MRI

☐ Ultrasound FNA
☐ Ultrasound core biopsy
☐ Mammographic-guided core OR vacuum assisted biopsy

On Warfarin?
☐ Yes INR: _____
☐ No

Thickening/lump: ≈
Scar: #
Skin lesion: O
Pain: X



PAST HISTORY OF BREAST DISEASE

☐ Nil

BENIGN
☐ Fibrocystic change
☐ Fibroadenoma
☐ Other (please describe):
_____

MALIGNANT
Stage: _____ Grade: _____
☐ DCIS
☐ LCIS
☐ Invasive ductal Ca
☐ Invasive lobular Ca
☐ Other (please describe):
_____

☐ Past breast surgery
date: _____
☐ WLE
☐ Axillary dissection
_____ involved lymph nodes
☐ Mastectomy
☐ Radiotherapy
☐ Chemotherapy
☐ Hormone therapy

CLINICAL DETAILS

This imaging is needed to (tick one and explain)
☐ Confirm
☐ Exclude
☐ Define
☐ Check the progress of

REFERRING PRACTITIONER

Name:
Address:
Phone: Fax:
Provider number:
Signature: Date:
Send copy to:

Patient to complete

MRI BREAST QUESTIONNAIRE

Previous breast imaging? ☐ yes ☐ no

If yes, what imaging and when?

☐ Mammography, date: _____

☐ Ultrasound, date: _____

☐ MRI, date: _____

Post-menopausal? ☐ yes ☐ no

If no, when was the start of your last period?

_____

On any form of HRT? ☐ yes ☑ no

If yes,

Date commenced: _____

Date ceased: _____

Type of HRT: _____

Number of pregnancies? _____

Did you breastfeed? ☐ yes ☐ no

Permanent breast implants? _____ ☐ yes ☐ no

If yes, are they: ☐ silicone ☐ saline

Family history of breast cancer? ☐ yes ☐ no

If yes, who in the family and what age were they at diagnosis?

_____

_____

Breast surgery? ☐ yes ☐ no

If yes, when? _____

For what reason? _____

Radiotherapy to either breast? ☐ yes ☐ no

Any lumps, discharge, thickening, or area of concern?

☑ yes ☐ no

If yes, please describe:

_____

_____

ANY OF THE FOLLOWING IMPLANTS, DEVICES, OR CONDITIONS?

Cardiac defibrillator/pacemaker/ pacing wires ☐ yes ☐ no

Heart valve replacement ☐ yes ☐ no

Aneurysm clip/coil ☐ yes ☐ no

Cochlear, stapes or other ear implants ☐ yes ☐ no

Eye implants ☐ yes ☐ no

Vascular stents /filters ☐ yes ☐ no

IVC filter ☐ yes ☐ no

Porta cath/vascular access port ☐ yes ☐ no

Neurostimulator ☐ yes ☐ no

Bone growth fusion stimulator ☐ yes ☐ no

Swan Ganz catheter ☐ yes ☐ no

Joint replacement, plates, pins, screws in any bones ☐ yes ☐ no

Please list: _____

Any other implants: _____

Shunt in brain or spine ☐ yes ☐ no

Insulin/infusion pump ☐ yes ☐ no

Glucose monitor ☐ yes ☐ no

Prosthetic limb/false body part ☐ yes ☐ no

Shrapnel or bullet injury ☐ yes ☐ no

Dentures (please remove before scan) ☐ yes ☐ no

Hearing aids (please remove before scan) ☐ yes ☐ no

Medication patch ☐ yes ☐ no

Tattoos or eye makeup ☐ yes ☐ no

Jewellery (please remove before scan) ☐ yes ☐ no

Claustrophobia ☐ yes ☐ no

Implant held in by a magnet ☐ yes ☐ no

Surgical clips, staples or metallic sutures ☐ yes ☐ no

Please list: _____

Pregnant ☐ yes ☐ no

Breastfeeding ☐ yes ☐ no

IUD ☐ yes ☐ no

Breast tissue expanders ☐ yes ☐ no

Have you had an endoscopy or colonoscopy in the last 6 weeks? ☐ yes ☐ no

Have you ever had an injury to your eyes involving metallic fragments? e.g. grinding injury ☐ yes ☐ no

If yes, was all of the metal removed by a medical professional? ☐ yes ☐ no