

**BreastCare Imaging**

1200 Burrard Street, Suite 406 | Located within Genetic Medical & Wellness  
Phone: 604.262.1044 | Fax: 844.811.0207



**BREASTCARE**  
IMAGING

## Supplemental Breast Ultrasound Screening Requisition

This requisition is for **screening purposes only**. This examination is not intended for diagnostic evaluation of breast symptoms (including palpable lumps, pain, nipple discharge, or skin changes).

Patient Name:		Date of Birth: yyyy-mm-dd)	
PHN:		Phone:	
Address:		Email Address:	

### Exam Requested

Supplemental Breast Ultrasound Screening (Bilateral)

### Clinical Information (Required)

Reason for Screening:	
Clinical History:	Date of Most Recent Mammogram: _____
Personal history of breast cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: type, year, treatment:	<p><b>* Please submit copy of most recent mammogram report with requisition</b></p> <input type="checkbox"/> Routine – Standard booking and reporting timeline <input type="checkbox"/> Urgent – Please expedite appointment and reporting  If Urgent, Clinical Reason:
Family history of breast cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: relationship(s), age at diagnosis:	
Known genetic mutation (e.g., BRCA): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Untested family member of a BRCA1 or BRCA2 carrier, or other known pathogenic gene variant carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

### Referring Physician

Physician Name:		MSP #:	
Clinic Name:		Phone:	
Fax:		Date:	

### Physician's Signature:

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