



Thunder Bay Regional
Health Sciences
Centre

ONTARIO BREAST SCREENING
PROGRAM

REQUISITION

Patient Name: _____
 Date of Birth (DD/MM/YYYY): _____
 HC#: _____
 Address: _____
 Postal Code: _____
 Primary Phone Number: _____
 Secondary Phone Number: _____

Guidelines for Use:

1. Complete all pertinent fields.
2. Complete requisitions are to be faxed to the OBSP at (807) 345-6602.
3. The OBSP will contact patient to book appointment.

Investigation Required:

- OBSP Screening Mammogram
- OBSP Recommendation: Women ages 50-74 receive a screening mammogram every 2 years
- Diagnostic Mammogram (Non-OBSP)
 (Screen for Life Coach Specific Investigation - **AVAILABLE OUTSIDE OF THUNDER BAY ONLY**)
- Non-OBSP Mammogram Indications (check all that apply):
 - Does not meet OBSP age guidelines (<50 or > 74)
 - Previous breast cancer
 - Breast implants
 - Other: _____

<u>Clinical History</u>	

Family Breast Cancer History:

- Mother Daughter Sister Other
 Age at Diagnosis: _____

Previous Mammogram:

- Yes No
 Dates: _____
 Location: _____

Physician or Nurse Practitioner (Print): _____

Signature: _____ Date: _____

* Physician or nurse practitioner must have ordering privileges at TBRHSC.

* If physician or nurse practitioner work at more than one clinic, please indicate preferred clinic for results delivery.

Copies of report to: _____

Note: Women can self-refer to the OBSP by calling (807) 684-7777 or 1-800-461-7031.