Thunder Bay Regional Health Sciences Centre

BREAST MAGNETIC RESONANCE IMAGING (MRI)

ADDITIONAL INFORMATION FORM

TO BE COMPLETED WITH MRI CONSULTATION REQUEST

FAX: 1-855-978-1862

Patient Name:_____

D.O.B. (YYYY-MM-DD):_____

Address:_____

City/Town, Prov:_____

Postal Code: _____Tel: _____

Health Card #: _____Version: ____

Place Patient Label with Barcode HerePlace

Is the patient hearing impaired? Yes ☐ No ☐

Does patient require an interpreter? Yes ☐ No ☐

PATIENT INFORMATION	**REFERRING PROVIDER INFORMATION (Please Print)**
Last Name	Name
First Name(s)	
Date of Birth _____ / _____ / _____ Day Month Year	Date

MENSTRUATION

☐ Patient still menstruating Date of Last Menstrual Period: _____

☐ Patient not menstruating Year of Last Menstrual Period: _____

HORMONE REPLACEMENT THERAPY

☐ Patient on hormone replacement therapy Duration (months/years): _____

☐ Patient previously on hormone replacement therapy Duration (months/years): _____ Date completed: _____

FAMILY CANCER HISTORY

☐ Patient BRCA (Breast Cancer) positive

☐ Family member Breast/Ovarian Cancer History ☐ Mother ☐ Sister ☐ Daughter ☐ Other: _____

☐ Maternal Grandmother ☐ Maternal Aunt ☐ Maternal Cousin

☐ Paternal Grandmother ☐ Paternal Aunt ☐ Paternal Cousin

PATIENT BREAST CANCER HISTORY

☐ Patient has History of Breast Cancer ☐ Right Side Date of Diagnosis: _____

☐ Left Side Date of Diagnosis: _____

☐ Lumpectomy ☐ Right Side ☐ Left Side Pathology: _____

☐ Mastectomy ☐ Right Side ☐ Left Side Pathology: _____

☐ Patient has had Radiation Therapy Date Completed: _____

PREVIOUS DIAGNOSTIC TESTS

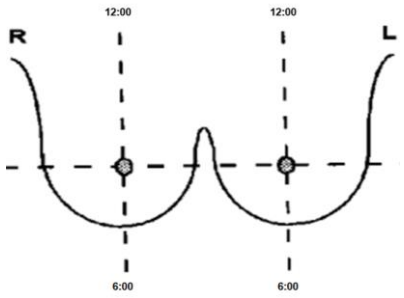
☐ Patient has had Previous Breast Biopsies ☐ Right Side Date/Year: _____ Pathology: _____

☐ Left Side Date/Year: _____ Pathology: _____

Date of Last Mammogram: _____

Date of Last Breast Ultrasound: _____

Diagram Scars or Physical Findings:



If patient has had their breast imaging performed outside of Thunder Bay Regional Health Sciences Centre, the images as well as the reports must be provided before the patient will be scheduled for their Breast MRI.

GUIDELINES for Completion:

1. **Referring Provider to complete in addition to the Magnetic Resonance Imaging (MRI) Consultation Request (FCS-001).**
2. **Fax both forms, including Regional referrals, to Diagnostic Imaging Central Intake 1-855-978-1862.**
3. **Incomplete referrals will be returned to the Referring Provider for completion.**
4. **Forms available from the Print Shop at Thunder Bay Regional Health Sciences Centre.**
5. **If patient has had their breast imaging performed outside of Thunder Bay Regional Health Sciences Centre, the images as well as the reports must both be provided before the patient will be scheduled for their Breast MRI.**