BREAST IMAGING REQUEST

Queensland Government

Royal Brisbane and Women's Hospital
Level 3, Ned Hanlon Building, Herston 4029
Phone: 3646 2606 Fax: (07) 3646 5379

Metro North Health

UR..... ☐ Female ☐ Male ☐ Indeterminate

Family Name.....

Given Names.....

DOB...../...../.....

Home address.....

Phone .....

☐ Inpatient Ward.....

☐ Outpatient Clinic.....

☐ **Interpreter Required - Language**.....

☐ 12 Months ☐ 6 Months ☐ Within 2 Weeks

☐ Urgent (arrange with Radiologist x 68172)

Date required.....

EXAMINATION REQUESTED

Imaging

☐ Mammogram
☐ Ultrasound
☐ Mammogram and Ultrasound
☐ MRI Breast - **reverse side must be completed**

Procedure

☐ Ultrasound biopsy
☐ Ultrasound drainage
☐ Ultrasound clip insertion
☐ Mammogram VAB
☐ MRI VAB

Antithrombotic drugs ☐ No ☐ Yes.....

Pre-operative localisation Date of procedure.....AM/PM, RBWH/STARS

☐ Ultrasound guided ☐ ROLLIS
☐ Mammogram guided ☐ Hookwire Localisation

PRIOR EXTERNAL IMAGING

☐ Yes, if so where and when? ☐ No

.....

If any prior imaging, please state location and arrange image transfer to RBWH PACS including reports.

RELEVANT FAMILY HISTORY

☐ Breast/Ovarian/Prostate Cancer

IMPORTANT PATIENT FACTORS

☐ Breast Implants ☐ Pregnant
☐ Limited Mobility ☐ Breastfeeding
☐ Cognitive impairment

Please include more information overside

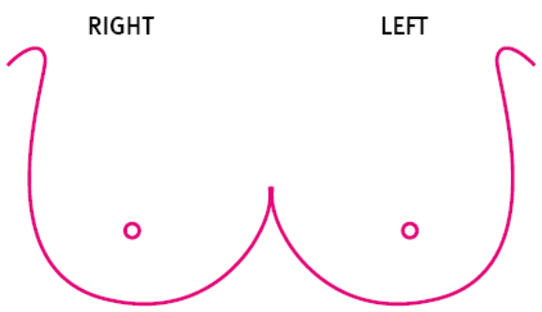
PAST HISTORY of *Breast Disease*

☐ Nil ☐ BRCA 1+ve ☐ BRCA 2+ve

BENIGN
☐ Fibrocystic change ☐ Fibroadenoma
☐ Other .....

MALIGNANT Stage ..... Grade .....
☐ DCIS ☐ LCIS
☐ Invasive ductal Ca ☐ Invasive lobular CA
☐ Other .....

☐ Past Breast Surgery ...../...../.....
☐ WLE ☐ Mastectomy
☐ SLNB/Axillary dissection ..... involved lymph nodes
☐ Radiotherapy ☐ Chemotherapy
☐ Hormone Therapy .....



Scars / surgery / biopsy
Acute clinical abnormality

Clinical Details ☐ No clinical concerns. Routine follow-up
or This imaging is needed to (tick one and explain)
☐ Confirm ☐ Exclude ☐ Define ☐ Progress of

Requested by ..... Consultant ..... Discussed with .....

Pager/Phone ..... Provider No .....

Signature ..... Date .....

Notice to the patient. For Medicare eligible examinations only: Your referrer has recommended that you use Queensland Health. You may choose another provider but please discuss this with your referrer first.

MRI BREAST QUESTIONNAIRE

Previous breast imaging? If yes, when?	Mammography - Ultrasound - MRI -
Post menopausal?	
If not, when was the start of their last period?	
Is the patient on Hormone Replacement Therapy? For how long?	
Number of pregnancies?	
Did the patient breastfeed?	
Breast implants? Ever had implants? What are they made of?	
Family history of breast cancer? If yes, who in the family and what age were they at diagnosis?	
Breast surgery? When? What for?	
Radiotherapy to either breast?	
Any lumps, discharge, thickening, or area of concern?	

Obligatory **MRI** questionnaire

Aneurysm clip	☐ Yes	☐ No	Programmable shunt	☐ Yes	☐ No
Embolisation coils	☐ Yes	☐ No	Metal prosthesis	☐ Yes	☐ No
Inner ear implant	☐ Yes	☐ No	Penetrating eye injury ever	☐ Yes	☐ No
Neuro/biostimulator	☐ Yes	☐ No	Stent	☐ Yes	☐ No
Heart surgery	☐ Yes	☐ No	Requires sedation/pain relief	☐ Yes	☐ No
Prosthetic cardiac valves	☐ Yes	☐ No	Requires GA	☐ Yes	☐ No
Cardiac pacemaker/wires	☐ Yes	☐ No	Claustrophobia	☐ Yes	☐ No
Vena cava filter	☐ Yes	☐ No	Able to lie flat	☐ Yes	☐ No

Consultant Name.....

Contact Details.....

Phone .....

Radiographers comments

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