Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

BREAST IMAGING

Needle Localization / Core Biopsy Procedure Request

BHC ☐ Priority 1 ☐ 2 ☐

Localization ☐ Core Biopsy ☐

By: Mammography ☐ By: Ultrasound ☐ Nuclear Medicine ☐

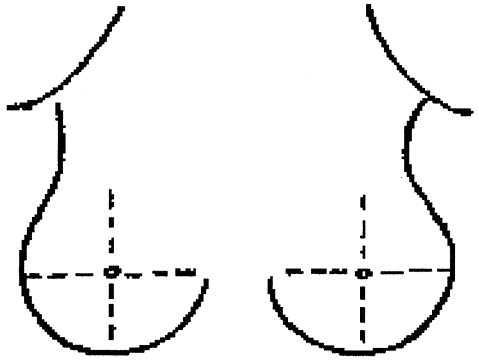
Consult ☐ Reason for consult: _____

Patient Name:	Date of Loc/ Biopsy:
Date of Birth:	Time of Loc/ Biopsy:
MH Medical Record Number:	Time of OR:
Surgeon and/ or Family Doctor:	Signature:

Post Ultrasound Needle Localization Unilateral Mammography	Right ☐	Left ☐
If any imaging required please proceed ☐ Ultrasound	Right ☐	Left ☐
Pre-procedure Imaging - Specify Mammo	Right ☐	Left ☐

Breast Side & Number of Sites:	Right ☐	1: ☐	2: ☐	Left ☐	1: ☐ 2: ☐
Axillary Node:	Right ☐	1: ☐	2: ☐	Left ☐	1: ☐ 2: ☐
Pre-Operative Sentinel Node	Right ☐			Left ☐	

RIGHT LEFT



RIGHT LEFT

Relevant History:	Prior imaging on PACS: ☐

Is Patient taking blood thinners? ☐ Yes ☐ No

If yes, specify: _____

Does the patient have any allergies? ☐ Yes ☐ No

If yes, please name them: _____

TECHNOLOGISTS' NOTES