

WOMEN'S IMAGING REFERRAL



PATIENT DETAILS

Patient name:

Date of birth:

Address:

Phone:

EXAMINATION

☐ Diagnostic assessment*
(may include mammogram, ultrasound, biopsy)

☐ Mammogram only*

☐ Ultrasound only

☐ MRI only

☐ Ultrasound FNA

☐ Ultrasound core biopsy

☐ Mammographic-guided core OR vacuum
assisted biopsy *

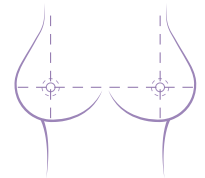
*only available at Qscan Windsor

Thickening/lump: ≈

Scar: #

Skin lesion: O

Pain: X



PAST HISTORY OF BREAST DISEASE

☐ Nil

BENIGN

☐ Fibrocystic change

☐ Fibroadenoma

☐ Other (please describe):

MALIGNANT

Stage: _____ Grade: _____

☐ DCIS

☐ LCIS

☐ Invasive ductal Ca

☐ Invasive lobular Ca

☐ Other (please describe):

☐ Past breast surgery

date: _____

☐ WLE

☐ Mastectomy

☐ Axillary dissection

_____ involved lymph nodes

☐ Radiotherapy

☐ Chemotherapy

☐ Hormone therapy

OBSTETRICS (ULTRASOUND)

☐ Follicle tracking

☐ Dating (< 12 weeks)

☐ Nuchal translucency
(12-13 weeks)

☐ Morphology (20 weeks)

☐ Growth check (> 22 weeks)

PELVIS (MRI)

REBATEABLE

☐ Known or suspected deep
endometriosis following pelvic
US for surgical planning

☐ Mullerian Duct Anomaly
investigation for sub-fertility
following US or HSG

☐ Uterine mass/fibroid seen on US
relating to sub-fertility (including
post treatment imaging)

☐ Evaluate for structural causes of
sub-fertility after two or more
failed IVF cycles

☐ Cervical carcinoma staging
following FIGO 1B histology
diagnosis

NON-REBATEABLE

☐ Uterine mass evaluation NOT
causing sub-fertility

☐ Adenomyosis evaluation

☐ Placental evaluation

☐ Adnexal mass evaluation

☐ Vaginal/vulva mass evaluation

☐ Urethral mass/diverticulum
evaluation

☐ Pelvic inflammatory disease
evaluation

☐ Other

CLINICAL DETAILS

REFERRING PRACTITIONER

Name:

Address:

Phone:

Fax:

Provider number:

Signature:

Date:

Send copy to:



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APPOINTMENT**

Your doctor has recommended you attend Qscan Radiology Clinics. You may choose another provider but please discuss this with your doctor first.
THANK YOU FOR CHOOSING QSCAN RADIOLOGY CLINICS.