YUKON MAMMOGRAPHY PROGRAM

BREAST SCREENING SELF-REFERRAL

To request a screening mammogram, please complete this form in full. We will mail you a letter with your appointment details once your booking has been confirmed.

Submit your form:

- **By Email**: ymp@yukonhospitals.ca
- **By Mail**: Whitehorse General Hospital, 5 Hospital Road, Whitehorse, YT, Y1A 3H7
- **By Fax**: 867-393-8775

Questions? Call us at 867-393-8738 for more information.

Patient information

First name	Last name	
Date of birth YYYY-MM-DD	Yukon Health Care Insurance Plan number	Phone
Accessibility needs (e.g. wheelchair, walker, and mobility aid)	City or community	

Primary care provider information

Do you have a primary care provider (e.g. Family doctor or nurse practitioner)? ☐ Yes ☐ No

If yes, provide the name of your primary care provider: _____
Name of primary care provider

If no, a primary care provider is required to review your screening mammogram results.

- By signing below I consent to medical imaging using the Yukon Midlife Clinic nurse practitioner as the referring provider for my mammogram screening.

_____ YYYY-MM-DD
Signature of patient — Date

Screening eligibility

Select all that apply:	Eligible for self referral	Provider referral required
Are you age 39 or younger?	☐ No	☐ Yes
Are you pregnant?	☐ No	☐ Yes
Are you breastfeeding?	☐ No	☐ Yes
Have you ever had breast cancer?	☐ No	☐ Yes
Do you now have a new lump, pain or nipple discharge?	☐ No	☐ Yes
Have you had breast implant surgery?	☐ No	☐ Yes

Note: If you answered **yes** to any questions, you are **not eligible to self-refer** for a screening mammogram. See a primary care provider to determine the most appropriate screening or diagnostic test for you.

Previous mammograms

Note: If your **most recent mammogram** was performed **outside of WGH**, please complete the authorization below. We will contact the facility to obtain your previous mammogram images and reports for comparison at the time of your appointment.

I authorize WGH to obtain my previous mammography images and reports from:

_____ YYYY-MM-DD
Name, address, and phone of facility — Date of previous exam

_____ YYYY-MM-DD
Signature of patient — Date signed

By completing and submitting this form to Yukon Hospital Corporation, you are consenting to the collection of Personal Health Information under the *Health Information Privacy and Management Act* (*HIPMA* s.(53)) and this consent may be withdrawn or withheld at anytime (*HIPMA* s.(39)(b)). Find out more at www.yukonhospitals.ca.