



Innovation is Everywhere— Why Isn't It Here?

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What about
healthcare?

What about healthcare?

VACCINES WORK			
DISEASE	CASES THEN*	CASES NOW**	DECREASE
WHOPPING COUGH	17,777	2,332	87%
MEASLES	53,584	292	99%
MUMPS	36,101	103	99%
RUBELLA	14,974	1	99%
DIPHTHERIA	8,142	1	99%
POLIO	2,545	0	100%





Hospital Site:	Date Ordered	Date Requested	Date Received
Appt. Date: _____ Time: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Surname	First Name
Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Address		
Language _____	City	Home Phone	
Order within 30 minutes with the radiologist/technologist	City of Birth (state/prov)	Work Phone	
<input type="checkbox"/> BREAST ULTRASOUND	Medical Plan Number	WCB / COBC Claim Number	
<input type="checkbox"/> MAMMOGRAPHY	<input type="checkbox"/> MBP <input type="checkbox"/> WCB <input type="checkbox"/> KBC <input type="checkbox"/> PATIENT <input type="checkbox"/> OTHER		
<input type="checkbox"/> RT <input type="checkbox"/> L <input type="checkbox"/> BILATERAL			

BREAST IMAGING REQUISITION

<input type="checkbox"/> Proceed to further imaging if indicated (Mammography or Ultrasound MRI)	
<input type="checkbox"/> Arrange needs history if indicated and feasible	
PLEASE MARK AREA(S) OF CONCERN:	
Right	Left
HISTORY: Previous Mammogram: <input type="checkbox"/> Yes <input type="checkbox"/> No All Locations: _____ Date: _____ Previous Ultrasound: <input type="checkbox"/> Yes <input type="checkbox"/> No All Locations: _____ Date: _____ Menopausal / LMP: _____ Hormone Therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No Family History of breast cancer: _____ Whipple: _____ Previous Biopsies / surgeries: _____ TECHNOLOGIST USE ONLY Notes: _____ # of Exposures: _____ Tech Initials: _____	
PRESENT COMPLAINT: <input type="checkbox"/> Lump <input type="checkbox"/> Thickening <input type="checkbox"/> Previous breast cancer <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Localized pain / tenderness <input type="checkbox"/> Abnormal Screening Mammogram <input type="checkbox"/> Follow-up of previous findings (specify): _____ <input type="checkbox"/> Dimpling, contour deformity <input type="checkbox"/> Breast prosthesis (implants) <input type="checkbox"/> Other (specify): _____	

• INCOMPLETE REQUESTS WILL BE RETURNED •

Requesting Physician: _____	Physician Signature: _____
Additional Copies of Report: _____	Billing to: _____
Address & phone: _____	Phone: _____ Fax: _____

FOR _____	DATE _____
ADDRESS _____	
REFILL _____ TIMES	
A generically equivalent drug product may be dispensed unless the practitioner hand writes the words "Brand Necessary" or "Brand Medically Necessary" on the face of the prescription.	
R_x	
SIGNATURE _____	DEA NO. _____
ADDRESS _____	
Reorder Item #6120	Total Pharmacy Supply, Inc. 1-800-878-2822



Healthcare Is Complex. People Are Too.



Encourage Failure, Lengthen Timelines



Privacy as Paternalism



Focus On What Matters Most



Thank you

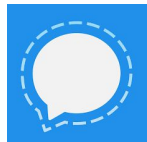
Questions?



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