CIBC BREAST ASSESSMENT CENTRE REFERRAL FORM

VF2.0

Fax referral and all previous non-HHS reports to 905-381-7084. Please complete all sections for all patients - incomplete referrals will be returned. We will fax your office an appointment to communicate to the patient.

I. REFERRING PROVIDER INFORMATION

Name (please print or use provider stamp)	Signature
	Date (dd/mm/yyyy)

II. PATIENT INFORMATION

Last Name	Date of Birth (dd/mm/yyyy)	Home Phone
First Name	Sex	Cell Phone
Initial(s)	OHIP #	Work Phone

III. REASON FOR REFERRAL

☐ Routine screening (asymptomatic) ☐ Follow-up of abnormal screen ☐ Request for ultrasound

☐ Ongoing surveillance (pt hx of breast ca) ☐ Patient is symptomatic ☐ Request for biopsy

☐ Short-term follow-up ☐ Other _____

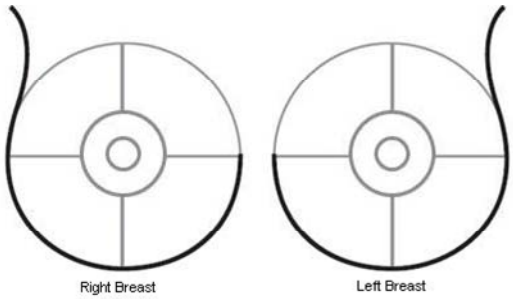
IV. PREVIOUS INVESTIGATIONS

Type (check all)	**At HHS Location** (do not attach report)	**At Other Location** (fax all non-HHS reports with referral)
☐ Mammogram	☐	☐ (please attach report)
☐ Ultrasound	☐	☐ (please attach report)
☐ MRI	☐	☐ (please attach report)
☐ Biopsy	☐	☐ (please attach report)

☐ No previous imaging/ investigations

V. CLINICAL HISTORY

Mark area(s) of concern



Symptoms (check all)

☐ Inflammatory or locally advanced cancer ☐ Suspicious lump

☐ Nipple changes _____ ☐ Fibrocystic breast changes

☐ Skin changes _____ ☐ Localized pain/ nodularity

☐ Bloody or watery nipple discharge ☐ Persistent or recurring cysts

☐ Other nipple discharge

Patient (check yes or no)	**No**	**Yes**
- has implants?	☐	☐
- is taking **anticoagulants**?	☐	☐

VI. SURGICAL CONSULT (not applicable for JCC physicians)

Your patient will be expedited to the next available surgeon should a consult be required. Please confirm:

☐ Yes, please expedite to next available surgeon should a surgical consult be required