Juravinski Hospital and Cancer Centre

CIBC BREAST ASSESSMENT CENTRE REFERRAL REQUEST

711 Concession Street, Hamilton, ON, L8V 1C3
Phone: (905)-521-2100 ext. 42497 Fax: (905)-381-7084
www.BAChamilton.ca

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) | Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

DATE (yyyy/mm/dd) _____

REFERRING PHYSICIAN _____

PHYSICIAN SIGNATURE _____ **OHIP Billing Number** _____

Phone: _____ (ext) _____ Back Line _____ Fax: _____

1. REASON FOR REFERRAL: (check all that apply)

☐ Screening mammogram (no symptoms)
☐ Surveillance mammogram (patient with history of breast cancer)
☐ Follow-up imaging → ☐ 3 months ☐ 6 months ☐ 12 months
☐ High Risk Breast / Ovarian Cancer Genetic Assessment
✸ If imaging also requested, please check separately

☐ Assessment of breast symptom
✸ Please complete section 2
☐ Breast biopsy
✸ Please complete section 2
☐ Recent abnormal mammogram
✸ See section 3

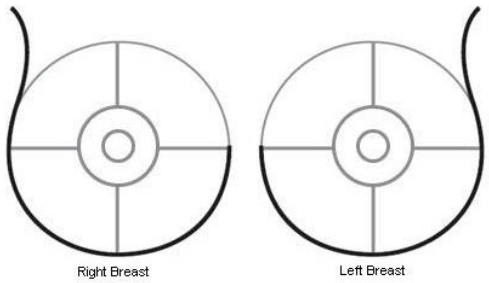
Please indicate if exam requested is: ☐ Bilateral **or** ☐ Unilateral Right **or** ☐ Unilateral Left

☐ Additional Information (include family history): _____

_____

2. CLINICAL HISTORY: Symptoms (check all that apply)

Mark area(s) of concern



☐ Breast lump
☐ Inflammatory / locally advanced cancer
☐ Nipple discharge – bloody / watery
☐ Acute breast symptom / breast abscess
☐ Other: _____

_____

☐ Localized breast pain
☐ Skin changes
☐ Nipple changes
☐ None

Does patient have implants? ☐ No ☐ Yes

Is patient taking anticoagulants? ☐ No ☐ Yes

3. PREVIOUS INVESTIGATIONS:

All previous breast imaging, investigations and consults must be faxed with your referral request.
This helps to expedite appointment booking and reduce patient delays.

4. PATIENT NAVIGATION

By signing this form, you authorize the CIBC Breast Assessment Centre to schedule all recommended diagnostic assessments and follow-ups including additional imaging, biopsies and follow up exams for abnormal results, genetic assessment and referral to next available surgeon.

Please indicate below if you have specific requests regarding patient navigation (eg. specific surgeon):

☐ _____

Please fax completed referral and accompanying documentation to 905-381-7084.
Incomplete referrals will be returned.
Confirmation of Appointment Date and Time will be provided via return fax to your office.

(Referral archived in patient's chart – PACS) **712577 (2021-04)**