

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

DATE (yyyy/mm/dd) _____

REFERRING PHYSICIAN _____

PHYSICIAN SIGNATURE _____

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

OHIP Billing Number _____

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ()	Ext.	
Cell Phone: ()		
Date of Birth (yyyy/mm/dd)	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F Gender:
HIN	Family Physician	

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

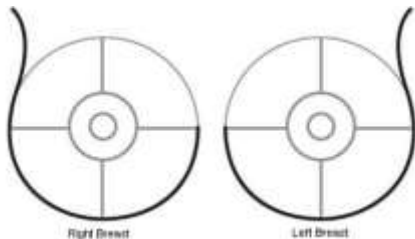
- | | |
|---|---|
| <input type="checkbox"/> Screening mammogram (no symptoms) | <input type="checkbox"/> Assessment of breast symptom
*please complete section 2 |
| <input type="checkbox"/> Surveillance mammogram (pt. with history of breast cancer) | <input type="checkbox"/> Breast biopsy
*please complete section 2 |
| <input type="checkbox"/> Follow-up imaging → <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months | <input type="checkbox"/> Recent abnormal mammogram
*please complete section 2 |
| <input type="checkbox"/> High Risk Breast/Ovarian Cancer Genetic Assessment
* if imaging also requested, please check separately | |

Exam requested is: Bilateral **or** Unilateral Right **or** Unilateral Left

Additional information (incl. family history): _____

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

Mark area(s) of concern



- | | |
|---|--|
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Localized breast pain |
| <input type="checkbox"/> Inflammatory / locally advanced cancer | <input type="checkbox"/> Skin changes |
| <input type="checkbox"/> Nipple discharge – bloody/watery | <input type="checkbox"/> Nipple changes |
| <input type="checkbox"/> Acute breast symptom / breast abscess | <input type="checkbox"/> None |
| <input type="checkbox"/> Other: _____ | |

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.

- No previous breast imaging
- Previous breast imaging attached, _____ # of attached reports.

4. PATIENT NAVIGATION (check all that apply)

By signing this form, you authorize the CIBC Breast Assessment Centre to schedule all recommended diagnostic assessment and follow-up 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 (e.g. 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.**