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	Sex ☐ M ☐ F Gender:
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 (pt. 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

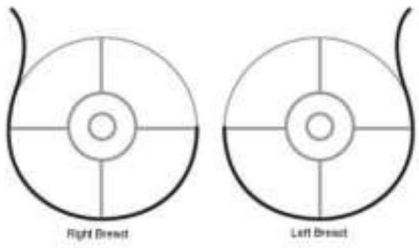
☐ Assessment of breast symptom
*please complete section 2
☐ Breast biopsy
*please complete section 2
☐ Recent abnormal mammogram
*please complete section 2

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



☐ 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.*

☐ 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.