BREAST SURGERY REFERRAL FORM

Breast Care Program
St. Joseph's Hospital
268 Grosvenor St.
London, ON N6A 4V2
Ph. 646-6000 x 65008
Fax. 519 646-6027

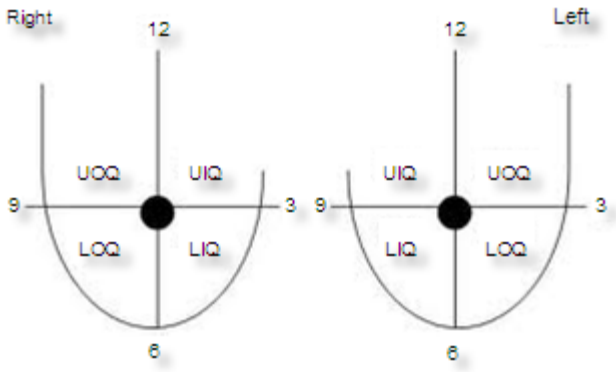
DATE REFERRAL FAXED: _____/_____/_____
Day Month Year

PATIENT INFORMATION

Last Name: _____
First Name: _____
Health Card No.: _____ VC: _____
Date of Birth: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone No. Home: _____ Work: _____

REASON FOR REFERRAL (check all that apply)

Please draw location of clinical finding.



☐ Palpable Lump Location: (☐ Right/☐ Left) _____
☐ Spontaneous Nipple Discharge
Bilateral ☐ Right ☐ Left ☐
☐ Breast Pain Bilateral ☐ Right ☐ Left ☐
☐ Breast Abscess
☐ BRCA Mutation
☐ Invasive Breast Cancer Diagnosis (outside St. Joseph's Hospital)
☐ Ductal Carcinoma *in situ*
☐ Local Recurrence – Previous Surgeon _____
☐ Second Opinion
☐ Other _____

Note: please refer any patients with family history assessment to CANCER GENETICS.

PLEASE CHECK PREFERENCE: ☐ Next Available Surgeon **OR** Surgeon of choice:
☐ Dr. M. Brackstone ☐ Dr. W. Davies ☐ Dr. S. Latosinsky ☐ Dr. A. Maciver ☐ Dr. S. Knowles ☐ Dr. A. Parsyan
(Please select as many as you wish)

REFERRING PHYSICIAN INFORMATION

Referring Physician Name: _____
Address: _____ City: _____
Province: _____ Postal Code: _____ Billing No.: _____
Phone: _____ Family Physician: _____
Referring Physician Signature: _____

FOR BREAST CARE CENTRE TRIAGE USE ONLY

MRN: _____
Priority Code: ☐ A ☐ B ☐ C ☐ D Staging ☐ CT Chest/Abdomen ☐ Bone Scan ☐ MUGA Scan for Priority 1
Referral to DI for Additional Imaging? Yes ☐ No ☐ Date of Completed DI: _____
Date Faxed Back to Referring Physician: _____
Patient Appointment Date: _____ With Dr.
_____
Signature of Central Triage NP: _____
Date of Triage: _____ Date of Referral: _____ Date of Consult: _____