St. Joseph's Hospital
Breast Care Program
268 Grosvenor St., P.O. Box 5777, Stn. B
London, ON N6A 4V2
Tel. (519) 646-6000 ext. 65020
Fax. (519) 646-6027

BREAST SURGERY CLINIC REFERRAL FORM

Please complete all sections and fax to the Breast Care Program **at (519) 646-6027**

1. DATE: _____/_____/_____
Day Month Year

2. REFERRAL FROM:

☐ University Hospital – ER ☐ St. Joseph's Urgent Care (UCC)
☐ Victoria Hospital - ER ☐ Other: _____

3. PATIENT INFORMATION – *please affix label or complete:*

Last Name: _____

First Name: _____

Date of Birth: _____/_____/_____
Day Month Year

Health Card No.: _____ VC: _____

Address: _____

City: _____ Postal Code: _____

Tel. Home: _____ Tel. Other: _____

Interpreter required? ☐ No ☐ Yes, language: _____

4. REFERRING PHYSICIAN INFORMATION

Referring Physician Name: _____

Address: _____

City: _____ Postal Code: _____

Billing No.: _____

Phone: _____

Fax: _____

Family Physician: _____

Physician Signature: _____

****NOTE:** By signing this requisition, you are providing authorization to St. Joseph's to order additional imaging for your patient if required for surgical consultation.

5. REASON FOR REFERRAL **(check all that apply)**

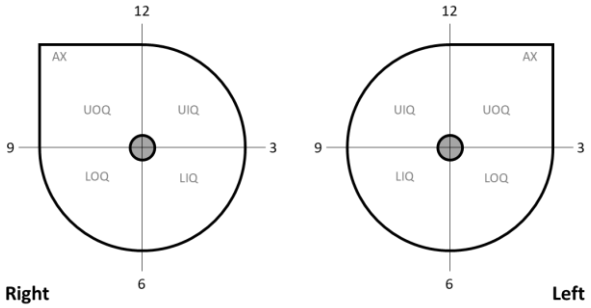
☐ ***New referral for this concern*** ☐ ***Repeat (re-referral) for this same concern***

	Bilateral	Left	Right
☐ Palpable lump			
☐ Spontaneous nipple discharge			
☐ Breast pain			
☐ Breast abscess			

- Abscess treated? Yes No
- If yes, medication prescribed: _____

☐ BRCA mutation
☐ Breast cancer (include imaging reports if done outside of St. Joseph's)
☐ Ductal carcinoma *in situ*
☐ Local recurrence – previous surgeon
☐ Second opinion
☐ Other: _____

Please draw in location of clinical finding:



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

6. PLEASE CHECK SURGEON PREFERENCE:

☐ Next available surgeon **OR**
☐ Surgeon of choice (please select as many as you wish):
☐ Dr. M. Brackstone ☐ Dr. W. Davies ☐ Dr. S. Latosinsky ☐ Dr. A. Maciver ☐ Dr. S. Knowles ☐ Dr. A. Parsyan

FOR BREAST CARE TRIAGE USE ONLY:

Priority code: ☐ **A** ☐ **B1** ☐ **B** ☐ **C1** ☐ **C** ☐ **D**

Referral to breast imaging for additional imaging? ☐ Yes ☐ No

Consult of guest imaging ☐ **Yes** ☐ **No**

Triage nursing signature: _____ Triage date: _____