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

BREAST SURGERY REFERRAL FORM

Please complete all sections and send to the Breast Care Program by **fax to 519 646-6027**

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

2. REFERRAL FROM:

☐ ER University Hospital ☐ St. Joseph's UCC
☐ ER Victoria Hospital ☐ Other

3. PATIENT INFORMATION

Last Name: _____
First Name: _____
Date of Birth: _____/_____/_____
Day Month Year
Health Card No.: _____ VC: _____
Address: _____
City: _____ Postal Code: _____
Tel. Home: _____ Tel. Other: _____

4. REFERRING PHYSICIAN INFORMATION

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

Physician Signature: _____

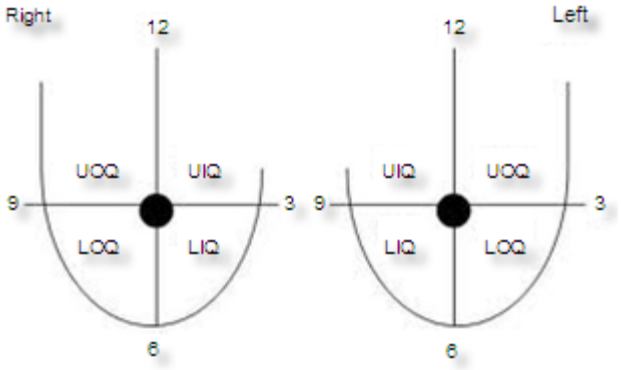
5. REASON FOR REFERRAL **(check all that apply)**

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

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

☐ BRCA mutation
☐ Invasive breast cancer, diagnosed outside St. Joseph's Hospital
☐ 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):
O Dr. M. Brackstone **O** Dr. W. Davies **O** Dr. S. Latosinsky **O** Dr. A. Maciver **O** Dr. S. Knowles **O** Dr. A. Parsyan

FOR BREAST CARE TRIAGE USE ONLY:

MRN: _____ Date of referral: _____
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 imaging completed: _____
Faxed back to referring physician date: _____
Patient appointment date (consult): _____ With surgeon, Dr. _____
Central triage NP signature: _____ Triage date: _____