

Fax referral and all previous non-HHS reports to 905-381-7084. Please complete all sections for all patients - incomplete referrals will be returned. We will fax your office an appointment to communicate to the patient.

I. REFERRING PROVIDER INFORMATION

Name (please <u>print</u> or use provider stamp)	Signature
	Date (dd/mm/yyyy)

II. PATIENT INFORMATION

Last Name	Date of Birth (dd/mm/yyyy)	Home Phone
First Name	Sex	Cell Phone
Initial(s)	OHIP #	Work Phone

III. REASON FOR REFERRAL

Routine screening (asymptomatic)
 Follow-up of abnormal screen
 Request for ultrasound
 Ongoing surveillance (pt hx of breast ca)
 Patient is symptomatic
 Request for biopsy
 Short-term follow-up
 Other _____

IV. PREVIOUS INVESTIGATIONS

Type (check all)	At HHS Location (do not attach report)	At Other Location (fax all non-HHS reports with referral)
<input type="checkbox"/> Mammogram	<input type="checkbox"/>	<input type="checkbox"/> (please attach report)
<input type="checkbox"/> Ultrasound	<input type="checkbox"/>	<input type="checkbox"/> (please attach report)
<input type="checkbox"/> MRI	<input type="checkbox"/>	<input type="checkbox"/> (please attach report)
<input type="checkbox"/> Biopsy	<input type="checkbox"/>	<input type="checkbox"/> (please attach report)
<input type="checkbox"/> No previous imaging/ investigations		

V. CLINICAL HISTORY

<p>Mark area(s) of concern</p> <p>Right Breast Left Breast</p>	<p>Symptoms (check all)</p> <input type="checkbox"/> Inflammatory or locally advanced cancer <input type="checkbox"/> Suspicious lump <input type="checkbox"/> Nipple changes _____ <input type="checkbox"/> Fibrocystic breast changes <input type="checkbox"/> Skin changes _____ <input type="checkbox"/> Localized pain/ nodularity <input type="checkbox"/> Bloody or watery nipple discharge <input type="checkbox"/> Persistent or recurring cysts <input type="checkbox"/> Other nipple discharge								
	<p>Patient (check yes or no)</p> <table border="0"> <tr> <td></td> <td>No</td> <td>Yes</td> </tr> <tr> <td>- has implants?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>- is taking anticoagulants?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		No	Yes	- has implants?	<input type="checkbox"/>	<input type="checkbox"/>	- is taking anticoagulants ?	<input type="checkbox"/>
	No	Yes							
- has implants?	<input type="checkbox"/>	<input type="checkbox"/>							
- is taking anticoagulants ?	<input type="checkbox"/>	<input type="checkbox"/>							

VI. SURGICAL CONSULT (not applicable for JCC physicians)

Your patient will be expedited to the next available surgeon should a consult be required. Please confirm:

Yes, please expedite to next available surgeon should a surgical consult be required