

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><b>Mark area(s) of concern</b></p> <p>Right Breast      Left Breast</p>	<p><b>Symptoms (check all)</b></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><b>Patient (check yes or no)</b></p> <table border="0"> <tr> <td></td> <td><b>No</b></td> <td><b>Yes</b></td> </tr> <tr> <td>- has implants?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>- is taking <b>anticoagulants</b>?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		<b>No</b>	<b>Yes</b>	- has implants?	<input type="checkbox"/>	<input type="checkbox"/>	- is taking <b>anticoagulants</b> ?	<input type="checkbox"/>
	<b>No</b>	<b>Yes</b>							
- has implants?	<input type="checkbox"/>	<input type="checkbox"/>							
- is taking <b>anticoagulants</b> ?	<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