NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Markham Stouffville Hospital
Oak Valley Health

Breast Health Centre Referral

Please fax to: 905-472-7607
Phone: 905-472-7606

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

Health Card # _____ Version Code: _____

☐ WSIB # _____ ☐ Non OHIP (Self-pay) or Refugee

Address: _____ Postal Code: _____

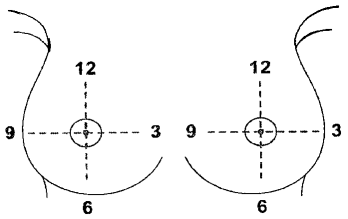
Telephone # (Best Daytime): _____

Alternate #: _____

Referral Date (dd/mm/yyyy)	**Referring MD**	**Signature**	**Telephone**
CPSO #	**Billing #**	**Address**	**Fax**
Preferred Language	Name & number of interpreter to help schedule appointment, if available **Please bring an interpreter to the appointment if required.**		

Reason for Referral *(check all that apply)*

- ☐ Abnormal Mammogram
- ☐ Abnormal Ultrasound
- ☐ Palpable Lump
- ☐ Bloody Nipple Discharge
- ☐ Patient has had breast cancer in the past
- ☐ Other: _____



Comments: _____

Past Medical History/Medication

Is patient taking blood thinners? ☐ No ☐ Yes, specify: _____

- **Please inform patient they must bring all external films to their clinic appointment**
- Markham Stouffville Hospital staff will contact your patient directly to schedule an appointment time.

***** All external reports MUST be faxed with this referral for appointment to be made ******

Attach to the referral:

- ✓ **Recent diagnostics (mammogram, US, MRI, pathology etc.) if not done at Markham Stouffville Hospital or Uxbridge Hospital**
- ✓ **Past Medical History and Medication (if not indicated above)**

Breast Health Centre Use Only

BHC appointment Date: _____ Time: _____ Physician: _____

Diagnostics required:

- ☐ Mammogram ☐ Left ☐ Right Time: _____
- ☐ Breast Ultrasound ☐ Left ☐ Right Time: _____
- ☐ Biopsy ☐ Ultrasound ☐ Stereotactic ☐ MRI
  ☐ Left ☐ Right Time: _____
- ☐ Ductogram ☐ Left ☐ Right Time: _____
- ☐ Consult External Films and Re-triage with Nurse Navigator

Last Mamommgram: _____ Last Ultrasound: _____

Previous BHC Physician: _____ Date: _____

Scheduling Notes: _____

Priority ☐ 1 ☐ 2 ☐ 3 RN Signature: _____