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: _____ (Day) _____ (Month) _____ (Year) Sex: F M

Health Card # _____ Version Code: _____

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

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

ALL reports MUST be attached to referral for appointment to be made including:

- ☐ All recent diagnostics reports (mammogram, US, MRI, pathology etc.)
- ☐ Past Medical History and Medication or CPP (cumulative patient profile)

NOTE: MISSING INFORMATION WILL RESULT IN RETURN OF REFERRAL AND DELAYED APPOINTMENT

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.**

Patient has been informed of referral to Breast Health Centre ☐ Yes ☐ No

Reason for Referral *(check all that apply)*

- ☐ Abnormal Imaging (e.g. MRI, mammogram, U/S)
- ☐ Abnormal Pathology ☐ Nipple inversion ☐ Skin changes
- ☐ Suspicious mass (☐ Palpable, ☐ non-palpable)
- ☐ Nipple Discharge (☐ bloody, ☐ clear, ☐ unilateral, ☐ bilateral)

Comments:

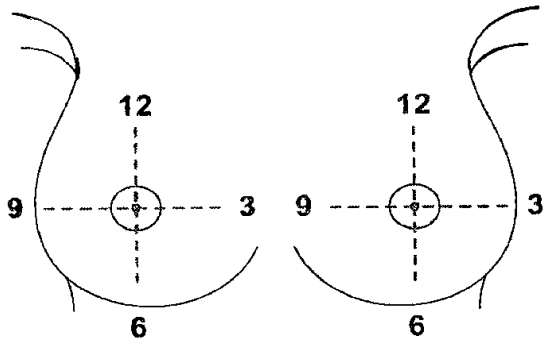
Family History

- ☐ Family History of a BRCA1 or BRACA2 mutation
- ☐ Family History of breast cancer (Please specify):

Personal History

- ☐ Personal History of a BRCA1 or BRACA2 mutation
- ☐ Personal History of breast cancer (Please specify):

Please mark area(s) of concern:



☐ Right ☐ Left

Medications

Patient on blood thinners? ☐ No ☐ Yes, specify: _____

Indication for blood thinner: _____

Note: Anticoagulation Guidelines will be faxed from BHC if biopsy required

Markham Stouffville Hospital staff will contact your patient directly to schedule an appointment time

Breast Health Centre Use Only

BHC appointment Date: _____ Time: _____ Physician: _____

Mammogram appointment Time: _____

U/S appointment Time: _____ Biopsy time: _____

Last Mamommgram: _____ Last Ultrasound: _____

Outside images available: _____

Previous BHC Physician: _____ Date: _____

Priority ☐ 1 (1 - 2 wks) ☐ 2 (4 wks) ☐ 3 (8 wks)

Medical Directive: _____

RN Signature: _____