



**Breast Diagnostic Clinic (BDC)
 REFERRAL FORM**

FORM SF0075

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Rev. 02/2019

Patient LABEL / Identification Area

All reports MUST be attached to referral for appointment to be made, including:

- ✓ Diagnostic reports from the past 5 years (mammogram, US, MRI, pathology, etc.)
- ✓ Past Medical History/medication or CPP (cumulative patient profile)

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

FAX #: 416-756-5986

Patient Information

Name: _____ Health Card # _____

Date of Birth (M/D/Y) _____ Gender: M F Phone #: _____

Address: _____ City/Town: _____ Postal Code: _____

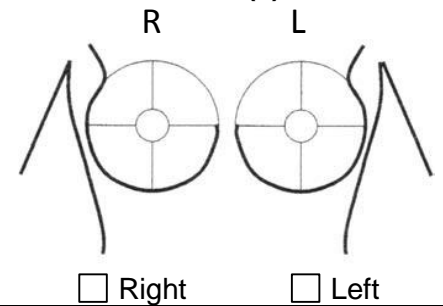
Reason for Referral

Clinical Abnormalities (check all that apply) :

- Suspicious mass (palpable / non-palpable)
- Nipple discharge (bloody / clear / unilateral / bilateral)
- Nipple inversion
- Skin changes
- Abnormal Imaging Abnormal Pathology

Other comments: _____

Please mark area(s) of concern:



Family or Personal History

- Family/Personal History of a BRCA1 or BRCA2 mutation
- Family History of breast and/or ovarian cancer: specify _____
- Personal History of breast and/or ovarian cancer: specify _____
- Radiation before age 30

Referring Physician Information (or stamp)

Name: _____
 Address: _____
 Phone: _____ Fax: _____
 Billing #: _____

Primary Care Physician Information

N/A: same as referring physician

Name: _____
 Address: _____
 Phone: _____ Fax: _____
 Billing #: _____

Referral to BDC Surgeon: Dr: _____ or Earliest available appointment

By completing this referral, I the referring practitioner hereby consent to any additional breast imaging (e.g. mammography, ultrasound) and/or biopsies that may be required.

Referring Practitioner Signature: _____ Date: _____

Internal Use

Date Received Referral to: BC ICC Medical Imaging

Approved By: Manager, BDC Approval Date: Jan/2019