



WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

76 Grenville Street
Toronto, Ontario
M5S 1B2

BREAST CENTRE REFERRAL FORM

T: 416-323-6225 F: 416-323-7730

Referral Date: ____/____/____
YYYY/MM/DD

Name: _____

DOB: _____

HC#: _____

Phone: _____

Address: _____

PATIENT IDENTIFICATION

REFERRING PROVIDER INFORMATION:

Name: _____ Billing #: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____

REASON FOR REFERRAL:

- Abnormal Imaging (Mammogram/Ultrasound/MRI - attach copy of reports)
- Abnormal Biopsy Results (attach copy of pathology report)
- High Risk Assessment and Screening (e.g. BRCA mutation, strong family history of cancer)
- Breast Reconstruction/Prophylactic Surgery
- Other: _____

CLINICAL FINDINGS: (e.g. lump, nipple discharge) please describe: _____

Does patient have family history of breast cancer? Yes No

If yes, please specify: _____

Date of last mammogram ____/____/____ last ultrasound ____/____/____ last MRI ____/____/____
YYYY/MM/DD YYYY/MM/DD YYYY/MM/DD

PLEASE NOTIFY THE PATIENT OF THE FOLLOWING APPOINTMENT:

DATE: ____/____/____ **TIME:** _____
YYYY / MM / DD

PHYSICIAN: _____ **LOCATION: 5TH FLOOR**

Patient must bring breast imaging on a CD or USB (in DICOM format) from the last 5 years. Yes No

Arrive 15 minutes prior to appointment – Refer to website for further information.

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