WCHI
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

76 Grenville Street
Toronto, Ontario
M5S 1B2

Name:

DOB:

HC#:

Phone:

Address:

PATIENT IDENTIFICATION

BREAST CENTRE REFERRAL FORM

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

Referral Date:_____/___/___
YYYY/MM/DD

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:** _____
Y Y Y Y / M M / D D

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.