fraserhealth

BREAST HEALTH CLINIC REFERRAL

JIM PATTISON OUTPATIENT CARE AND SURGERY CENTRE

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Fax Completed Referral Forms to 604-587- 4543 **Phone: 604-582-4563**

**** INCOMPLETE DOCUMENTS WILL BE RETURNED****

Patient's Full Legal Name: _____ (Last) _____ (First) _____ (Middle)

Personal Health Number: _____ **Date of Birth:** ___/___/___ (DD, MM, YYYY) **Gender: M** ☐ **F** ☐

Home Phone No. _____ ☐ Okay to Call **Message Phone No.** _____

Insurance Type ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay Other: _____ RCMP or Armed Forces #: _____

Interpreter Required: ☐ **No** ☐ **Yes** **Language:** _____

Examination Requested

☐ Mammography ☐ Breast Ultrasound ☐ Rt ☐ Lt ☐ Bilateral

☐ I understand and agree that referral to the Breast Health Clinic includes Medical Imaging, a clinical examination (breast surgeon) and a core biopsy if indicated

☐ Proceed to further imaging if indicated (Mammography/Ultrasound/MRI)

☐ Arrange biopsy if indicated

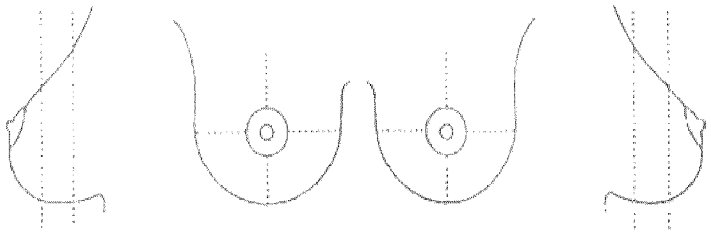
FOR CLINIC USE ONLY

Present Complaint: (see back for referral criteria)

☐ Lump
☐ Thickening
☐ Nipple discharge/inversion/skin changes
☐ Localized pain/tenderness
☐ Dimpling, contour deformity
☐ Previous breast cancer (new symptoms)
☐ Abnormal Screening Mammogram
☐ Re-referral to Breast Health Clinic
☐ Follow up of previous findings
Specify: _____
☐ Other Specify: _____

Please Mark Area(s) of Concern:

☐ Right ☐ Left ☐ Bilateral



History:

Previous Mammograms: ☐ Yes ☐ No
Location: _____ Date: _____
Location: _____ Date: _____

Previous Ultrasound: ☐ Yes ☐ No
Location: _____ Date: _____
Location: _____ Date: _____

Previous images/reports requested
Date: _____

Menopause / LMP: _____

Hormone Therapy: ☐ Yes ☐ No

Family History of Breast Cancer ☐ Yes ☐ No
Relationship _____ Age _____

Previous Biopsies / Surgeries: _____

****Clinic appointment <u>will not be booked</u> until all previous breast imaging/reports received ****

Family Physician (if different from referring source)

Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

Referring Health Care Provider:

Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ GP ☐ Specialist ☐ NP ☐ Hospitalist ☐ ER ☐ Other

Referring Physician Signature: _____

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BREAST HEALTH CLINIC REFERRAL
Cont'd

Referral Criteria for Breast Health Clinic

- Women and men
- Patients 17 years and older
- Patients with breast symptoms such as:
    - o Lump
    - o Breast tissue thickening or fibrocystic changes
    - o Nipple discharge/nipple inversion/skin changes
    - o Localized pain and tenderness
    - o Dimpling or contour deformity
    - o Axilliary mass
- Patients with an abnormal screening mammogram.
- Patients with abnormal diagnostic imaging results.
- Patients with previous breast cancer with new breast symptoms or abnormal imaging findings.
- Patients requesting a second opinion.
- Previous Breast Health Clinic patients without a definitive diagnosis who require follow-up (must be re-referred to Breast Health Clinic by GP).