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:** _____

Present Complaint: **(see back for referral criteria)**

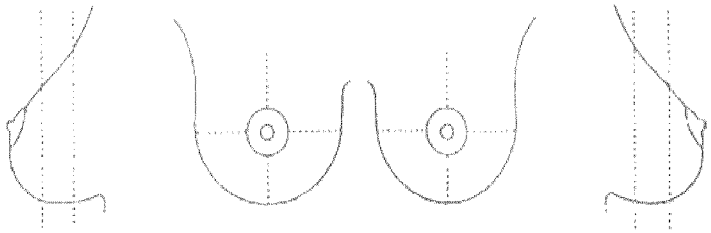
- ☐ Lump
- ☐ Thickening
- ☐ Nipple discharge ☐ Single ☐ Bilateral
- ☐ Nipple inversion/skin changes
- ☐ Localized pain/tenderness
- ☐ Dimpling, contour deformity
- ☐ Previous breast cancer (new symptoms)
- ☐ Abnormal Screening Mammogram
- ☐ Re-referral to Breast Health Clinic
- ☐ Follow up of previous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

Specify: _____

- ☐ Other Specify: _____

Please Mark Area(s) of Concern:

☐ Right ☐ Left ☐ Bilateral



****Clinic appointment <u>will not be booked</u> until all previous breast imaging reports and films are received with the referral form****

History:

Previous Mammograms: ☐ Yes ☐ No

Location: _____ Date: _____

Previous Ultrasound: ☐ Yes ☐ No

Location: _____ Date: _____

☐ **Previous images requested**

Date: _____

Menopause / LMP: _____

Pregnant: ☐ Yes ☐ No

Hormone Therapy: ☐ Yes ☐ No

Family History of Breast Cancer ☐ Yes ☐ No

Relationship _____ Age _____

Previous Biopsies / Surgeries: _____

_____

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

☐ 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

Referring Physician Signature: _____

FOR CLINIC USE ONLY

☐ Mammography ☐ Breast Ultrasound ☐ Rt ☐ Lt ☐ Bilateral

☐ Arrange biopsy if indicated

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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).

**** We do not accept patients who are Self Pay (Private Clinics and Bellingham accept self-pay)****