

NOTE: Incompleted and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

BREAST HEALTH CENTRE REFERRAL

Please Fax to: (905) - 472 - 7607
Phone: (905) - 472 - 7606

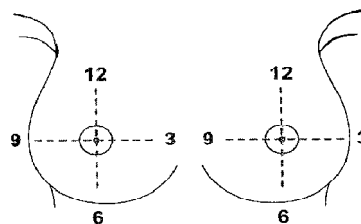
Hospital MRN#:
Patient Name: Last First
Date of Birth (DD/MM/YY): Sex: F M
Health Card #: Version Code:
Address: Postal Code:
Telephone # (Best Daytime):
Alternate #:

Date Referring MD Signature
Telephone Fax

Spoken Language if other than English Please bring translator to the appointment if required.

Reason for Referral (check all that apply)

- Abnormal Mammogram
Abnormal Ultrasound
Palpable Lump
Bloody Nipple Discharge
Patient has had breast cancer in the past
Other:



Comments:

Past Medical History/Medication

Is patient taking blood thinners? No Yes, specify:

- Please inform patient they must bring all external films to their clinic appointment
MSH staff will contact your patient directly to schedule an appointment time.

All external reports MUST be faxed with this referral for appointment to be made

Attach to this referral:

- Recent diagnostics (mammogram, US, MRI, pathology etc.) if not done at MSH or UCH
Past Medical History and Medication (if not indicated above)

Breast Health Centre Use Only

BHC appointment Date: Time: Physician:

Diagnostics required:

- Mammogram Left Right Time:
Breast Ultrasound Left Right Time:
Biopsy Ultrasound Stereotactic MRI Left Right Time:
Ductogram Left Right Time:
Consult External Films and Re-triage with Nurse Navigator

Last Mammogram: Last Ultrasound:

Previous BHC Physician: Date:

Scheduling Notes:

Priority 1 2 3

RN Signature: