Erie Shores HealthCare
Care Happens Here

Breast Assessment Referral Form

INCOMPLETE REQUESTS WILL BE RETURNED, resulting in delay or cancellation.
Fax Completed Requests to 519-326-4916. For questions, call 519-322-2501 EXT 4000

1. Patient Information - Please affix Label or complete

Last Name: _____ **First Name**: _____

Date of Birth (mm/dd/yyyy): _____ **Gender**: _____

Health Card #: _____, Version: _____

Address: _____ **City**: _____

Postal Code: _____ **Email**: ___

Phone # :(day) _____ (evening) _____

Pregnant or breastfeeding? ☐ Y ☐ N

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift

Interpreter Required? ☐ Y ,language: _____ ☐ N

2. Referring Physician Information

Referring Physician: _____

Address: _____

City: _____ **Postal Code**: _____

Billing #: _____

Phone #: _____

Fax #: _____

Family Physician: _____

Screening for patients 40 years to 74 years with no symptoms or previous breast cancer: patient to call the Ontario Breast Screening Program (OBSP) to book ** 519-322-2501 EXT 4000**

3. Previous Imaging *if not ESHC, please attach breast imaging reports

☐ No ☐ Yes, when (mm/dd/yyyy) _____ & where? _____ *

4. Reason for Referral - Note: Breast Screening Ultrasound is not routinely performed at ESHC

Does the patient have breast implants?
☐ Y, type: ☐ Silicone ☐ Saline
☐ N

Appointment for: ☐ **Screening**
☐ **Bi-Rads 3**
☐ **Diagnostic -** New clinical concern: ☐ N ☐ Y
Please describe, _____

5. History / Clinical Findings *REQUIRED

☐ **History of Breast Cancer** ☐ **Mastectomy**

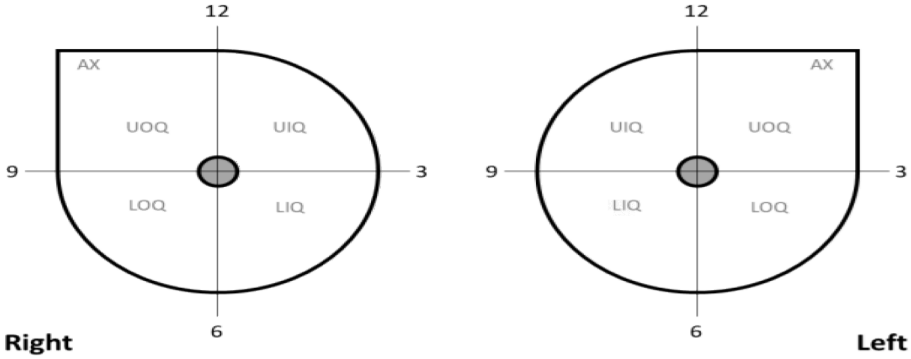
☐ **Palpable lump:** (☐ R ☐ L), **first detected by:** ☐ patient ☐ physician

☐ **Pain:** (☐ R ☐ L), **type of pain**: ☐ focal ☐ diffuse ☐ intermittent

☐ **Nipple Discharge (**only if spontaneous, non-milky**):** (☐ R ☐ L), **type of discharge:** ☐ bloody ☐ other: _____

History/Findings: _____

6. Indicate all clinical concerns on diagram



7. Referring Physician Signature - By signing, you are providing authorization to ESHC for your patient to receive additional imaging and urgent surgical consultation, as required, to resolve this diagnostic request.

_____ _____
Signature Date (mm/dd/yyyy)

ESHC Use Only

Appointment Date/Time (mm/dd/yyyy; 00:00 hrs) _____

Exam: BA Mammo - ☐ R ☐ L ☐ Bilat **BA Ultrasound -** ☐ R ☐ L ☐ Bilat ☐ **Other**: _____