BREAST ASSESSMENT REFERRAL FORM

Please complete all sections and fax to 519-646-6201

St. Joseph's use only:					Exam date: _____
	BA Mammo	Right	Left	Bilat	
	BA Ultrasound	Right	Left	Bilat	
	Other:				

1. PATIENT INFORMATION – *please affix label or complete:*

Last Name: _____

First Name: _____ Middle initial: ___

Preferred name: _____ Pronouns: _____

Birth Sex: ☐ Female ☐ Intersex ☐ Male ☐ Prefer not to disclose

Date of birth: _____/_____/_____
Year *Month* *Day*

Health Card No.: _____ VC: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ alternate tel.: _____

Email: _____

☐ Long-Term Care resident ☐ No ☐ Yes: _____

2. REFERRING PHYSICIAN INFORMATION

Referring physician: _____

Address: _____

City: _____ Postal Code: _____

Billing No.: _____

Phone: _____

Fax: _____

Family physician: _____

** **Screening for patients aged 40 to 74 years with no symptoms and no previous breast cancer:** patient can self-schedule OBSP appointment at www.sjhc.london.on.ca/book-breast-screening or call (519) 646-6105 **

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical lift

Interpreter required? ☐ No ☐ Yes, language: _____

Pregnant? ☐ No ☐ Yes, how many months: _____

Breastfeeding? ☐ No ☐ Yes, how many months: _____

3. PREVIOUS IMAGING done outside of St. Joseph's? ☐ No ☐ Yes

If yes, when? _____

Where? _____

4. REASON FOR REFERRAL

Patient history of breast cancer? ☐ No ☐ Yes

Does the patient have breast implants? ☐ No ☐ Yes

If yes, indicate type: ☐ Silicone ☐ Saline

Appointment for:

- ☐ **Non-OBSP SCREENING****
- ☐ **BI-RADS 3**
- ☐ **New Clinical Concern**

5. New clinical findings:

	Right	Left	
Palpable lump			Lump detected by: ☐ Patient ☐ Physician
Pain			☐ Focal ☐ Diffuse ☐ Intermittent
Nipple discharge *(only if spontaneous, non-milky)*			Type of discharge ☐ Bloody ☐ Other:

Description: _____

_____

_____

6. Patient Screen for Serum Creatinine

History of impaired renal function or nephrectomy? ☐ No ☐ Yes

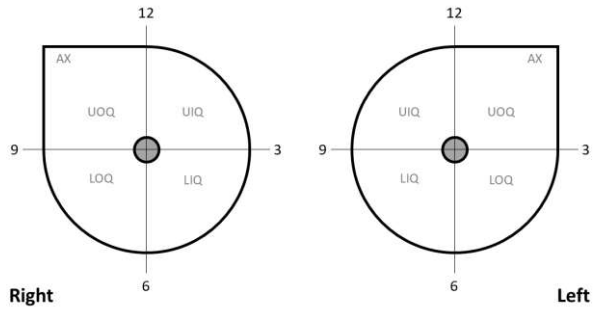
Taking medications or has conditions predisposing to nephrotoxicity? ☐ No ☐ Yes

Allergy to radiographic contrast? ☐ No ☐ Yes

If YES to any of the questions in section 6, please provide serum creatinine (must be drawn within the past **3 months**):

Result: eGFR: Sample date:

7. Please indicate all clinical concerns on diagram



8. NOTE: By signing this requisition, you are providing authorization to St. Joseph's for your patient to receive additional imaging and urgent surgical consultation, as required, to resolve this diagnostic request.

9. Physician signature: _____