

BREAST ASSESSMENT REFERRAL FORM

Please complete all sections and fax to 519-646-6204

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

1. PATIENT INFORMATION – please affix label or complete:

Last Name: _____
 First Name: _____ Middle initial: _____
 Gender: _____ Date of birth : _____/_____/_____
Day Month Year
 Health Card No.: _____ VC: _____
 Address: _____
 City: _____ Postal Code: _____
 Telephone (day): _____ (evening): _____
 Email: _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical lift
Interpreter required? ☐ No ☐ Yes, language: _____
 Are you **pregnant or breastfeeding?** ☐ No ☐ Yes

2. REFERRING PHYSICIAN INFORMATION

Referring physician: _____
 Address: _____
 City: _____ Postal Code: _____
 Billing No.: _____
 Phone: _____
 Fax: _____
 Family physician: _____

****Screening for patients 40 years to 74 years with
 no symptoms or previous breast cancer:
 patient call St. Joseph's OBSP (519) 646-6105 to book****

3. PREVIOUS IMAGING? ☐ No ☐ Yes When? Where? _____

** Please attach breast imaging reports NOT generated at St. Joseph's*

4. REASON FOR REFERRAL

Does the patient have breast implants? ☐ No ☐ Yes
 If yes, indicate type: ☐ Silicone ☐ Saline

Appointment for:

- ☐ **SCREENING**
☐ **BI-RADS 3**
☐ **DIAGNOSTIC**

☐ New Clinical Concern ☐ No ☐ Yes

If yes, please describe: _____

5. HISTORY/CLINICAL FINDINGS (required):

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

History/Findings: _____

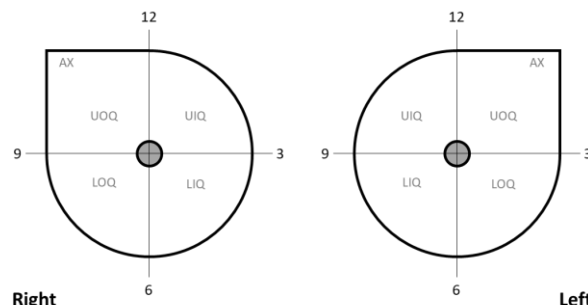
6. Patient Screen for Serum Creatinine

- History of impaired renal function or nephrectomy? ☐ No ☐ Yes
 Taking medications for diabetes? ☐ 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



*****SCREENING BREAST ULTRASOUND IS NOT ROUTINELY PERFORMED AT ST. JOSEPH'S HEALTH CARE LONDON*****

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: _____