

Rapid Access Breast Clinic Referral Form



Rapid Access Breast Clinic

Mount Saint Joseph Hospital
3080 Prince Edward Street,
Vancouver, BC V5T 3N4

Tel: 604-877-8511
Fax: 604-877-8506

MR MISS MRS MS PERMANENT ADDRESS		SURNAME		FIRST NAME	
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE		
DATE OF BIRTH (MONTH / DAY / YEAR)			AGE	SEX	
HEALTH CARE #		MSP <input type="checkbox"/>	WCB <input type="checkbox"/>	ICBC <input type="checkbox"/>	OTHER <input type="checkbox"/>

Appointment Date: _____ Time: _____

<p>History</p> <p>Previous Mammograms: <input type="checkbox"/> YES <input type="checkbox"/> NO Location: _____ Date: _____ (Within last 2 years)</p> <p>Previous Ultrasound: <input type="checkbox"/> YES <input type="checkbox"/> NO Location: _____ Date: _____ (Within last 2 years)</p> <p>Menopause / LMP: _____</p> <p>Anticoagulation Therapy: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Previous Biopsies/Surgeries: _____</p> <p>Present Complaint: <input type="checkbox"/> Lump <input type="checkbox"/> Thickening <input type="checkbox"/> Previous breast cancer <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Localized pain / tenderness <input type="checkbox"/> Abnormal Screening Mammogram <input type="checkbox"/> Follow-up of previous findings Specify: _____ <input type="checkbox"/> Dimpling, contour deformity <input type="checkbox"/> Breast prosthesis (implant) <input type="checkbox"/> Others Specify: _____</p>	<p>Exam Requested</p> <p><input type="checkbox"/> Mammography <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Ultrasound <input type="checkbox"/> Bilateral <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p>I agree to allow the radiologists to use their discretion in the choice of imaging techniques and subsequent tissue sampling. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>I agree to have my patient see one of the Breast Clinic surgeons if a surgical consult is required. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Please Mark Area(s) of Concern</p>		
	DATE _____ SIGNATURE OF AUTHORIZING PHYSICIAN _____		
	Please Print NAME _____ Prac. No. _____		
	TEL: _____ FAX: _____		
	ADDITIONAL COPY OF REPORT TO: _____		
	<i>Incomplete requests will be returned.</i>		
	Technical Impression		
	<table border="1"> <tr> <td>Tech</td> <td>Rad</td> </tr> </table>	Tech	Rad
Tech	Rad		

