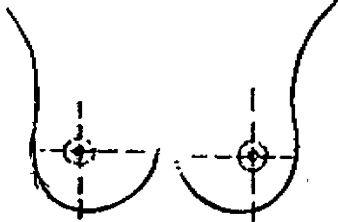


<b>Referral Source</b> (Who is referring this patient?) <input type="checkbox"/> Patient's Family Physician <input type="checkbox"/> Other Family Physician (locum, etc) <input type="checkbox"/> Radiologist / DI <input type="checkbox"/> Surgeon <input type="checkbox"/> Cancer Centre <input type="checkbox"/> _____	<b>Alternate Contact</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship to patient: _____ Phone: _____	<b>Patient Info</b> (cover with patient label if label provides all info) PHN / ULI: _____ Birth Date: ____ - ____ - ____      Gender: <input type="checkbox"/> F <input type="checkbox"/> M <small style="margin-left: 100px;">dd      mon      yyyy</small> Name: _____ <small style="margin-left: 100px;">last                                  first                                  middle</small> Address: _____ City: _____      Postal Code: _____ Phone: (h) _____ (alt) _____	
<b>Information about Referral Source</b>		<b>Information about Family Physician</b>	
Name: _____ Phone _____ Fax _____ Address: _____ Postal Code: _____ Prac ID: _____		Name: _____ Phone _____ Fax _____ Address: _____ Postal Code: _____ Prac ID: _____	
<b>Service(s) Requested</b>		<b>Criteria for Diagnostic Imaging and Triage</b>	
<input type="checkbox"/> DI Workup In the event <b>DI results are normal</b> , would you like a referral to a medical breast expert? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Surgical Consult Referral <input type="checkbox"/> Patient Education/Info <input type="checkbox"/> Patient Psychosocial support <input type="checkbox"/> Medical Breast Expert (Specialist)		<input type="checkbox"/> Lump or thickening <input type="checkbox"/> Localized, significant pain <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Dimpling <input type="checkbox"/> Bloody <input type="checkbox"/> Skin changes <input type="checkbox"/> Non-bloody <input type="checkbox"/> _____	
<b>Most Recent Breast Study</b> (if known)		<b>Referral Source's Estimate of Cancer Risk:</b>	
<b>Date:</b> (dd-mon-yyyy)	<b>Location/Site</b>	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> Known cancer diagnosis    } <b>If <input checked="" type="checkbox"/>, is patient aware of cancer diagnosis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Location of Abnormality</b>		<b>Right Breast</b>	<b>Left Breast</b>
		<input type="checkbox"/> Axilla <input type="checkbox"/> Nipple <input type="checkbox"/> ____ o'clock <input type="checkbox"/> Other _____	<input type="checkbox"/> Axilla <input type="checkbox"/> Nipple <input type="checkbox"/> ____ o'clock <input type="checkbox"/> Other _____
<b>Special Issues and Requirements</b> (please specify)			
Breast implants <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Family history of: <input type="checkbox"/> breast cancer <input type="checkbox"/> ovarian cancer <input type="checkbox"/> Patient has been diagnosed with cancer previously. <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Anticoagulant(s): _____ <input type="checkbox"/> Oxygen-dependent <input type="checkbox"/> Visual impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Interpreter required (language: _____) <input type="checkbox"/> Mobility limitations: _____ <input type="checkbox"/> Other: _____		<b>Other Comments</b> (if known)	
		<input type="checkbox"/> Patient's family physician cannot access Netcare and requests fax of results to ( ____ ) _____ <input type="checkbox"/> Return results via _____ PCN <input type="checkbox"/> _____	
Thank you for referring your patient to this program.			