NOTE: Incompleted and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN#: _____

Patient Name: _____
Last First

Date of Birth (DD/MM/YY): _____ Sex: F M

Health Card #: _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

BREAST HEALTH CENTRE REFERRAL

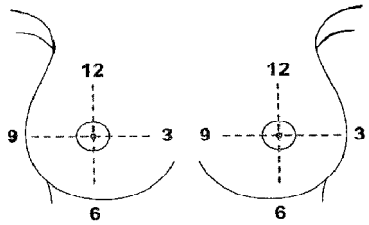
Please Fax to: (905) - 472 - 7607
Phone: (905) - 472 - 7606

Date	Referring MD	Signature
Telephone		Fax

Spoken Language if other than English **Please bring translator to the appointment if required.**

Reason for Referral *(check all that apply)*

- ☐ Abnormal Mammogram
- ☐ Abnormal Ultrasound
- ☐ Palpable Lump
- ☐ Bloody Nipple Discharge
- ☐ Patient has had breast cancer in the past
- ☐ Other: _____



Comments: _____

_____

Past Medical History/Medication

Is patient taking blood thinners? ☐ No ☐ Yes, specify: _____

- **Please inform patient they must bring all external films to their clinic appointment**
- MSH staff will contact your patient directly to schedule an appointment time.

***** All external reports MUST be faxed with this referral for appointment to be made*****

Attach to this referral:

- ✓ **Recent diagnostics (mammogram, US, MRI, pathology etc.) if not done at MSH or UCH**
- ✓ **Past Medical History and Medication (if not indicated above)**

Breast Health Centre Use Only

BHC appointment Date: _____ Time: _____ Physician: _____

Diagnostics required:

- ☐ Mammogram ☐ Left ☐ Right Time: _____
- ☐ Breast Ultrasound ☐ Left ☐ Right Time: _____
- ☐ Biopsy ☐ Ultrasound ☐ Stereotactic ☐ MRI ☐ Left ☐ Right Time: _____
- ☐ Ductogram ☐ Left ☐ Right Time: _____
- ☐ Consult External Films and Re-triage with Nurse Navigator

Last Mammogram: _____ Last Ultrasound: _____

Previous BHC Physician: _____ Date: _____

Scheduling Notes: _____

Priority ☐ 1 ☐ 2 ☐ 3 RN Signature: _____