Breast Health Program Referral

BC Women's Hospital & Health Centre
4500 Oak Street, Vancouver, BC V6H 3N1
Tel: 604-875-3705 Fax: 604-875-3080

- ☐ **Please print.**
- ☐ **Fax all relevant information with this referral form.**
- ☐ **We will contact your patient directly with an appointment time unless otherwise directed.**
- ☐ **Please list your phone and fax # at the bottom of this page for any future communications**

PATIENT NAME: _____ DOB (ddmmyy):_____

ADDRESS: _____ PHN: _____

_____ POSTAL CODE: _____

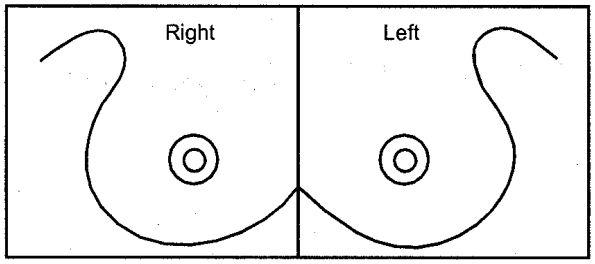
TELEPHONE: (H)_____ (W) _____(C) _____

Reason for referral:

1. ☐ **Abnormal SMP Exam**. SMPBC ID#: _____ (Please fax SMP letter)

2. ☐ **Signs of abnormality** (please choose)
__ Lump/Thickening
__ Nipple Discharge - (Spontaneous? Y / N, Colour _____)
__ Other
_____

Please indicate location of abnormality
If there has been a previous biopsy, please note scar on the diagram and send pathology report



3. ☐ **Review of Outside Imaging for:**
__ 2nd Opinion
__ Stereo Biopsy – ***as recommended by Radiologist or Surgeon only***

4. ☐ **Other** _____

PLEASE NOTE: Referrals cannot be processed without completion of the following section.
Please list ALL relevant breast imaging exams and procedures or indicate if no previous breast imaging has been performed.

Procedures: Mammograms (Screening &/or Diagnostic), Ultrasound, Biopsies/Pathology Reports	Date performed	Name of outside facility
1)		
2)		
3)		

Referring MD:_____ Billing: #:_____ Phone #: _____ Fax: _____

Family MD: _____ Billing: #: _____
(if different from above)
Referring Physician's Signature: _____ Date (DDMMYY): _____