ST JOSEPH's HEALTH CARE LONDON

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 <u>no</u> 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 (only if spontaneous,non-milky) ☐ Right ☐ Left
Type of discharge ☐ Bloody ☐ Other:

History/Findings: ______________________

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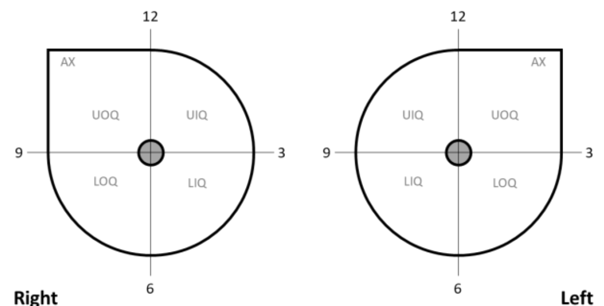
6. Patient Screen for Serum Creatinine

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. JOSEPHS 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: ______________________

Revised: Oct. 2024