Mackenzie Health

**Mackenzie Richmond Hill Hospital**
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

**Cortellucci Vaughan Hospital**
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000



# BREAST HEALTH CLINIC

*Patient Referral Form*

**Telephone:** 905-883-1212 Ext. 3245 **Fax:** 905-883-0772

****Referring MD, please note sending this referral will assume you support proceeding with all necessary imaging and/or biopsy recommended for a full workup.**

## Patient Information

Last Name: ______________________ First Name: ______________________

Address: *Street:* ______ *Apt:* ______ *City/Town* ______ *Province* ______ *Postal Code* ______

Home Number: ______________ Business Number ______________ Other: ______________

Date of Birth ______________ (dd/mm/yyyy)

Health Card Number: ______________________ Version Code: ______________

## Referring Physician Information

Referring Physician: ______________________ Referral Billing Number: ______________________

Address: *Street:* ______ *Apt:* ______ *City/Town* ______ *Province* ______ *Postal Code* ______

Office Number: ______________________ Fax: ______________________

## Reason for Referral

☐ Abnormal Breast Imaging (must attached to referral)

☐ Positive Core Biopsy

☐ Nipple Discharge
Description ______________________

☐ Suspicious Mass

☐ 2nd Opinion

☐ Other ______________________

* If patient is over 30, please facilitate mammogram and ultrasound, if under 30 years of age ultrasound may be sufficient.

If no breast imaging is attached, it may result in delay as the referral may be rejected. Please attach recent (within 6 months) breast imaging to avoid delay.

Is patient aware of referral? ☐ Yes ☐ No

Is patient on anticoagulation therapy? ☐ Yes ☐ No

**Appointment Information:** Mackenzie Health will notify patient of appointment date and time.