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*

**Phone:** 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: _____

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

Address: _____

Home Number: _____ Business Number _____ Other: _____

Date of Birth _____ (dd/mm/yyyy)

Health Card Number: _____ Version Code: _____

## Referring Physician Information

Referring Physician: _____ Referral Billing Number: _____

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

Address: _____

Office Number: _____ Fax: _____

## Reason for Referral

Right Breast _____ Left Breast _____ Location: _____

Palpable Abnormality _____

Abnormal Mammogram _____

Abnormal Ultrasound _____

Is patient aware of reason for referral? ☐ Yes ☐ No

**Please list or attach a cumulative patient profile**

**Medications**

Aspirin ☐ Yes ☐ No

Plavix ☐ Yes ☐ No

Coumadin ☐ Yes ☐ No

Other_____

Allergies _____ ☐ No Known Allergies

Latex ☐ Yes ☐ No

Anaesthetic ☐ Yes ☐ No

Other _____

## Additional Section

**Please advise patients to bring all outside Mammography and Ultrasound Images to their clinic appointment**

Mammography Report Attached _____ Study Date: _____(dd/mm/yyyy)

Ultrasound Report Attached _____ Study Date: _____(dd/mm/yyyy)

## Appointment Information

Patient notified of appointment date and time.

☐ will attend ☐ will not attend