Bluewater Health

Cancer Care Assessment and Treatment Centre

Patient Name:

PHYSICIAN REFERRAL FORM

DOB (dd/mm/yy): ☐ M ☐ F	Referring Physician:
Address: City:	Telephone: Fax:
Postal Code:	Physician Signature:
HCN & VC:	Family Physician/ Nurse Practitioner:
Telephone 1: Telephone 2:	Patient notified of referral to DAP: ☐ Yes ☐ No Patient aware of cancer risk: ☐ Yes ☐ No Referred to Medical Oncology ☐ Yes ☐ No Patient aware of Pathology ☐ Yes ☐ No

History of presenting illness / concern: _____

_____

Pertinent Health History: ☐ Other: _____

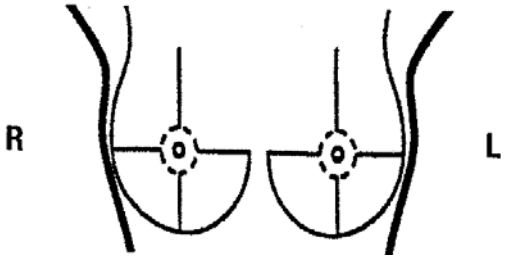
☐ Coronary Artery Disease/CHF ☐ Liver Cirrhosis ☐ COPD on home Oxygen ☐ CVA/TIA

☐ Diabetes ☐ Anti Coagulation ☐ Kidney Dialysis ☐ Prosthetic Valve/Previous Endocarditis

BREAST DIAGNOSTIC ASSESSMENT PROGRAM

☐ **Referral for Breast Assessment Program** (for mammogram and/or ultrasound and/or biopsy)

☐ Lump in breast – size _____
☐ Lump in Axilla – size _____
☐ Recent nipple retraction
☐ Nipple discharge
☐ Abnormal breast imaging
☐ Nipple eczema
☐ Skin changes, indentation, peau d'orange



ABNORMAL BREAST IMAGING FROM EXTERNAL FACILITY: Copies of test results must accompany referral

CLINIC LOCATION: Date: _____ Test: _____ Result: _____

_____ Date: _____ Test: _____ Result: _____

SURGICAL CONSULTATION

☐ **Imaging Completed with Positive Pathology Results** (Preferences honoured if consultation occurs within 14 days)

Preferred Surgeon: ☐ First Available **or** ☐ Dr. R. Kareemi ☐ Dr. R. Suryavanshi ☐ Dr. A. Muhunthan ☐ Dr. P. Taylor ☐ Dr. A. Rudovics

Fax completed form to 519-346-4608

CCATC Direct Line 519-464-4485