BLUEWATER HEALTH

Breast Assessment and Surgical Referral
Patient Navigator Phone 519-464-4485

Place Patient Label Here

Referral accepted by FAX
Please fax completed form to 519-383-8532
Breast Assessment and Surgical Referral

Name: _____

Date of Birth :_____/_____ / _____
DD MM Year

Gender: ☐Female ☐ Male

Address: _____

Phone: _____

Referring Provider_____

Signature:_____

Phone: _____ Fax: _____

Primary Health Care Provider: _____

Note: By signing this referral, you are providing authorization to Bluewater Health for your patient to receive additional imaging and urgent surgical consultation, as required, to resolve this request.,

(It is the responsibility of the Ordering Healthcare Provider to review test results with patient before we contact them)

Patient Aware of Pathology: ☐ Yes ☐ No Referred to Medical Oncology: ☐ Yes ☐ No

Pertinent Health History:

☐ CAD / CHF ☐ COPD ☐ CVA/TIA ☐ Kidney Disease ☐ Diabetes ☐ Liver

☐ Anti-Coagulation ☐ Prosthetic Valve / Previous Endocarditis

☐ Other:_____

History of Presenting Illness or Concerns

_____

_____

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: _____

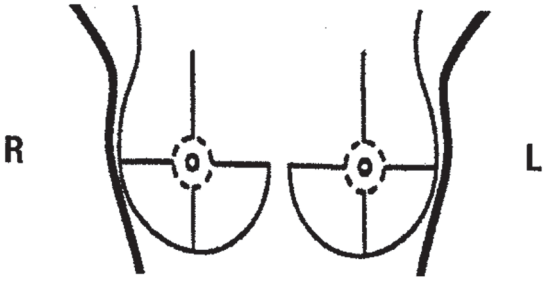
☐ Recent nipple retraction ☐ Pain

☐ Nipple discharge ☐ Nipple eczema

☐ Skin changes, indentation

☐ Abnormal breast imaging

☐ Implants/ reconstruction



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 will be given if consultation occurs within 14 days)

☐ First Available Surgeon **OR** ☐Dr. R. Kareemi ☐Dr. R. Suryavanshi ☐Dr. P. Taylor ☐Dr. C. Way