BLUEWATER HEALTH

Breast Assessment and Surgical Referral

Patient Navigator Phone 519-464-4485

Place Patient Label Here

Referral accepted through OCEAN eReferral Network or 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: _____

_____

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: _____

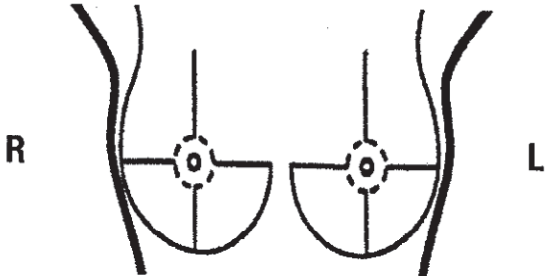
Recent nipple retraction Pain

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. A. Muhunthan