MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

BREAST DIAGNOSTIC ASSESSMENT CLINIC REFERRAL FORM

TEL: (416) 469-6031 FAX: (416) 469-6458

REF

☐ **Routine** ☐ **Urgent**

Patient ID Label

Patient Last Name:	Given Name:	☐ M ☐ F	Date of Birth: (DD / MMM / YYYY)
Address:	Apt#:		Telephone Number – Primary Number: ( )
Town or City:	Province:	Postal Code:	Telephone Number – Work Number: ( )
Contact Person (Caregiver/Parent/Guardian:	Relationship To Patient:		Telephone Number - Contact Person: ( )

Family Physician:	**Ontario Health Card Number:** Version Code	**Email Address For Virtual Consult:**

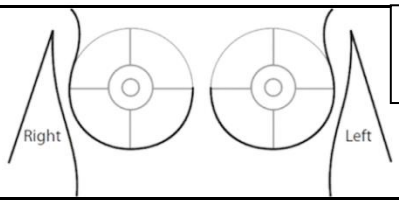
Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown

Required Questions:	PRIVACY: If we call the patient, can we leave a voice message? ☐No ☐Yes WSIB: Is this treatment due to a work related injury? ☐No ☐Yes American Sign Language interpreter required? ☐No ☐Yes Language interpreter required? - specify: ☐No ☐Yes

Referred To:	☐ First Available Appointment ☐ Dr. Hany Sawires ☐ Dr. Thomas Gilas	Referral Date:

Reason For Referral:

☐ Palpable Breast Lump
☐ Suspicious Mammogram / Ultrasound
☐ Nipple Discharge
☐ Abnormal/Change in Breast Appearance
☐ Other:



Date of Suspicious Findings:

IMPORTANT!

Please send all pertinent lab reports, mammogram & ultrasound reports.

If you have schedule a mammogram or ultrasound, please record the date of the appointment.

Investigations To Date: * **Mammogram and/or ultrasound report(s) are required prior to the consultation appointment date.**
☐ Mammogram* ☐ Ultrasound* ☐ Pathology Reports ☐ Procedures Notes ☐ Consultation Notes
☐ Other Tests:

Reason for Referral:

Past Medical History:

Medications:

Referring Physician:	Physician Name:	
	Telephone Number: ( )	Fax Number: ( )
	Physician's Signature:	Billing#:

Appointment Information:	

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Ontario eServices Program

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