Trillium Health Partners

BREAST DIAGNOSTIC ASSESSMENT PROGRAM REFERRAL FORM

Phone | 1-866-530-4464
Fax | CVH 1-877-530-4425 and QH 416-521-4036

Unit #:
BIRADS: ☐3 ☐4 ☐5
Date received:
DAP-QH/DAP-CVH:

Reset Form

TO ENSURE REFERRAL IS ACCEPTED, please include the following: 1) Abnormal breast mammogram and/or ultrasound radiology report(s); 2) Completed referral form with indicated reason for referral; and 3) other reports which pertain to the referral.

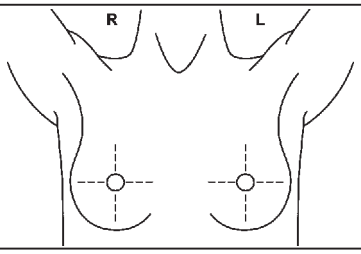
Patients will be provided an appointment once breast imaging has been received and reviewed by Trillium Health Partners. By signing this referral, you are aware and consent to all investigations being booked on your behalf until definitive diagnosis (i.e. mammography, ultrasound, and biopsy procedures).

Patient Information (AFFIX PATIENT LABEL)	REFERRING PHYSICIAN INFORMATION (STAMP)
Last Name:	Referring Physician Name:
First Name:	Address:
Health Card #: V.C.:	Phone:
Date of Birth:	Fax:
Address:	Billing #:
City:	Family physician name:
Province: Postal Code:	***Referring Physician Signature:***
Phone #1:	
Phone #2:	
Phone #3:	

REASON FOR REFERRAL (check all that apply)

- ☐ Abnormal Imaging (Mammogram, Ultrasound, MRI) *Reports Enclosed Location: _____
- ☐ Palpable Lump ☐ with abnormal imaging ☐ without abnormal imaging *Reports Enclosed
- ☐ Suspicion of Inflammatory Breast Cancer (distinct changes to skin, swelling, rash, redness, orange-peel skin)
- ☐ Other: _____

Indicate area of concern:



Current Medications (i.e. blood thinners):

Allergies:

COMMENTS:

Breast Diagnostic Assessment Program / Diagnostic Imaging Office ONLY

Type of Referral: ☐ Internal | ☐ External | ☐ Tacit | Imaging Location: _____
☐ Already in Impax
Date entered into Database: _____

NAVIGATOR TRIAGE (Date Sent: _____ Date Triaged: _____)

☐ Book Surgical Consult | ☐ Inappropriate Referral (Refer to surgeon's office)
☐ Book biopsy (No Rad Consult Req'd); Biopsy Type: ☐ Same-Day (if possible) | ☐ U/S Guided Bx | ☐ Stereo Bx
Notes:

Date sent to DI: _____ Imaging Reports obtained? ☐ Y ☐ N
Date Imaging Reports/Images Requested/Received: _____ / _____
Date sent back to DAP: _____ More images required: ☐ Y ☐ N | Date/Time of biopsy: _____ ☐ N.A.
Patient Contact *(if N written, indicates another call required; if date written, successful attempt [1st patient contact date])*
Attempt 1: _____ Attempt 2: _____ Attempt 3: _____
Date/Time of appointment: _____
Surgeon: ☐ G.M. / ☐ D.K. / ☐ A.N. / ☐ C.M. / ☐ M.K. / ☐ J.R. / ☐ Other: _____

2864 D HR (January/2017)