Sunnybrook
ODETTE CANCER CENTRE

Breast Rapid Diagnostic Unit (RDU) Fax-In Referral Form

Please FAX form and documents to
New Patient Booking Office (Breast Centre):

Fax: (416) 480-4676

Date of Referral (YYYY/MM/DD): _____

PATIENT IDENTIFICATION

All patients referred to the breast RDU will receive a mammogram, an ultrasound, and if deemed necessary by a Sunnybrook Breast Imaging Radiologist, a core biopsy and/or a Fine Needle Aspiration (FNA) biopsy.

In the event that no biopsy is required, the patient will not be assigned to a Sunnybrook physician for their results. Any additional exams/follow-up suggested would be the responsibility of the referring physician to order.

REASON FOR REFERRAL:

Patient has been informed of referral to Breast Rapid Diagnostic Unit? ☐ Yes ☐ No

☑ Option A (recommended)	Patient diagnosis communicated by, and subsequent care managed by the **1st available Sunnybrook Breast Surgery Physician**
☐ Option B	Patient diagnosis communicated by, and subsequent care managed by the Sunnybrook Breast Surgeon specified below. NOTE: Delays may occur if the surgeon is not immediately available. ☐ Dr. Look Hong ☐ Dr. Roberts ☐ Dr. Wright
☐ Option C	Patient diagnosis communicated by, and subsequent care managed by the referring physician. NOTE: Clinical concordance will be the responsibility of the referring physician.

PATIENT INFORMATION

Last Name:_____ First Name:_____

OHIP#:_____ Version Code:_____ DOB (D/M/Y):_____

Sex: ☐ Male ☐ Female ☐ _____ Does patient speak English? ☐ Yes ☐ No ☐ Other (specify):_____

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Business/Cell Phone:_____

Patient on blood thinners? ☐ Yes ☐ No (If yes, please specify below)
☐ ASA/Asprin ☐ Dalteparin/Fragmin ☐ Heparin ☐ Plavix ☐ NSAIDs ☐ Warfarin/Coumadin ☐ Other:_____

DOCTOR INFORMATION

Referring Physician:_____ Billing#:_____

Phone:_____ Ext._____ Secure Fax #:_____

SUPPORTING DOCUMENTATION: Patients with prior imaging will be given an appointment once Breast Imaging films, CDs and reports have been delivered to the Breast RDU.

Please also fax the following, if available:		
Referral Letter/H&P	☐	☐
Mammogram Reports (last 5 years)	☐	☐
Breast Ultrasound Reports	☐	☐
Breast Biopsy Reports	☐	☐
Breast MRI Report	☐	☐

Odette Cancer Centre New Patient Booking Office (Breast Centre)
Phone #: (416) 480-5000 ext. 7938

Note: We will notify the referring doctor and the patient of the appointment.

Referring Physician Signature:

_____

OCC OFFICE USE ONLY

HFN Number:_____

RDU Booked:_____ Date Booked:_____ Time Booked:_____

Clinic appointment called to: ☐ Referring Physician ☐ Hospital ☐ Patient ☐ Other (specify): _____