

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

<input checked="" type="checkbox"/> Option A (recommended)	Patient diagnosis communicated by, and subsequent care managed by the 1st available Sunnybrook Breast Surgery Physician
<input type="checkbox"/> 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. <input type="checkbox"/> Dr. Holloway <input type="checkbox"/> Dr. Look Hong <input type="checkbox"/> Dr. Wright
<input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>
Mammogram Reports (last 5 years)	<input type="checkbox"/>	<input type="checkbox"/>
Breast Ultrasound Reports	<input type="checkbox"/>	<input type="checkbox"/>
Breast Biopsy Reports	<input type="checkbox"/>	<input type="checkbox"/>
Breast MRI Report	<input type="checkbox"/>	<input type="checkbox"/>

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): _____

