Lakeridge Health
Durham Regional Cancer Centre

Breast Diagnostic Assessment Program
Breast Surgeon Consult Form
Telephone: 905−576−8711 ext. 36414
Fax : 905−721−4872

Date of Referral: _____ (dd/mm/yy)

❒ **Patient has been informed of this referral**

The Breast Assessment Program will provide patients with timely access to an interdisciplinary team: surgeon, nurse navigator, pathologist, and other health disciplines, i.e. social worker as required. A nurse navigator will participate in facilitating the plan of care.

Referring Physician
By signing this form, you confirm patient is aware of this referral
Name: _____
Address: _____
Phone: _____ Fax: _____
Physician Signature: _____
Physician Billing Number: _____

Family Physician (if different from referring):
Name: _____
Address: _____
Phone: _____ Fax: _____

Patient Information (name as it appears on Health Card)
HCN# _____ VC ____ Unique # _____ Date of Birth: _____
Surname: _____ Given Name: _____ Initial: _____
Address: _____ Town: _____
Postal Code: _____ Home Phone: _____ Work: _____

Reason for Referral:
❒ Abnormal Breast Imaging Findings ❒ Positive Core Biopsy ❒ Suspicious Breast Lump
❒ 2nd Opinion ❒ Other: _____
Is patient on anticoagulation therapy? ❒ Yes ❒ No
If patient is over 40 years of age please arrange mammogram and ultrasound.

Tests Completed	Test Done at (Name of Diagnostic Facility) Outside−reports must be attached	Date
❒ Mammogram		
❒ Ultrasound		
❒ Fine Needle Aspiration		
❒ Core Biopsy		

Please include history and updated medication list
If applicable, submit ***ALL*** breast imaging reports from the past 5 years with this referral.

Comments/Specifics: _____

Breast DAP use only	
❒ Breast Imaging−Priors Only	Surgeon: _____
❒ Radiologist Consult	Appointment Date & Time: _____
	Nurse Navigator: _____