NORTH OKANAGAN BREAST CANCER REFERRAL FORM

INCOMPLETE REFERRALS WILL NOT BE ACCEPTED

Patient must be aware of diagnosis. All of the following are REQUIRED:

✓ Bilateral mammogram
✓ Targeted Breast Ultrasound
✓ Pathology report showing invasive or in-situ carcinoma or other breast malignancy

MRI, CT scan, bone scan and lab work **NOT** required for referral.

Please fill out the entire form and fax to number in the ROUTING section below

PATIENT INFORMATION
Last name
First name
Date of birth mmm dd yy
PHN
Primary contact number
Email address

REFERRER INFORMATION
Referring primary care provider
MSP #
Clinic name Address Phone Fax
Primary care provider full name ☐ Same as referring

REFERRAL INFORMATION

Refer to	Special considerations	Attached results
☐ **First Available Surgeon**	☐ Patient requesting oncoplastic surgery	✓ Bilateral mammogram
☐ Requested Surgeon(s)	☐ Patient requesting aesthetic flat mastectomy	✓ Breast Ultrasound
☐ Dr. Scott Ainslie	☐ Suspected inflammatory breast cancer	✓ Pathology report
☐ Dr. Jeff Demetrick	☐ Triple negative (ER/PR/HER2 negative)	☐ Biomarker results
☐ Dr. Michael Horkoff	☐ HER2 positive	☐ MRI
☐ Dr. Hamish Hwang	☐ Previous breast cancer	☐ CT chest abdomen pelvis
☐ Dr. Karl Langer	☐ 40 year of age or less	☐ Bone Scan
☐ Dr. Quinn Parker	☐ Confirmed BRCA gene mutation	☐ Lab work
☐ Dr. Kevin Wiseman	☐ Pregnant	**Please attach patient's medical history if available**
	☐ Connective tissue disorder (eg lupus, scleroderma)	

ROUTING

For Dr. Hamish Hwang only FAX to 250-545-2781 **For all other referrals FAX to 250-545-8212**	Date referral sent mmm dd yy	Total # of pages faxed

This section to be completed by surgical office to fax back to referring clinic and pathology dept

Accepting surgeon	Date referral accepted mmm dd yy	Date of consultation appointment mmm dd yy
Pathology dept to add accepting surgeon to future specimen pathology addenda – FAX 250-541-3501		
☐ Incomplete referral. PLEASE RESUBMIT WITH ALL REQUIRED INFORMATION		Date referral sent back mmm dd yy
☐ Simultaneous referral to medical oncology for neoadjuvant chemotherapy		Date referral forwarded mmm dd yy