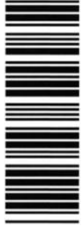

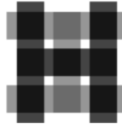

BREAST CANCER LYMPHEDEMA CARE

Referral Form

Please check appropriate boxes

Patient Name: ___________________________

MRN: __________________________________

Phone number: ___________________________

Most Responsible Physician: _______________________________

Reason for Referral (please check all that apply):

- ☐ Axillary lymph node dissection surgery
- ☐ Heaviness, tightness or tingling in your arm or affected area
- ☐ Changes in the skin texture of your arm or affected area
- ☐ Discomfort and intermittent swelling in the arm or around the affected area
- ☐ Other________________

Treatment Plan:

Date of breast cancer surgery: ________________

Type of breast cancer Surgery:___________________

Will radiation be part of the patient's treatment? Yes ☐ No ☐ If yes, date of radiation: ________________

Comments:

____

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Referring Physician Signature: ____

Date:__________________________________

North York General Lymphedema Care| BMO Breast Daignostic Centre, North York General Hospital, General Site, 4001 Leslie Street, 1st Floor, Toronto, ON M2K 1E1, Telephone: (416) 756-6816 Fax: (416) 756-5986 | lymphedema_coordinator@nygh.on.ca