NORTH YORK GENERAL
Making a World of Difference

REFERRAL FORM

The Charlotte and Lewis Steinberg
Familial Breast/Ovarian Cancer Clinic

Referral Date:

PATIENT NAME: ____________________

DOB: ____________________ ☐ **Male** ☐ **Female**
yy / mm / dd

Health card #:____________________
Version code

Address: ____________________

____
City Postal code

Home #: ____________________

Work #: ____________________

Cell #:____________________

Patient affected with cancer?
☐ **No** ☐ **Yes**
Type of cancer ______________
(Please send pathology / surgical report)
Recent Diagnosis? *(in the last 3 mos)*
☐ **No** ☐ **Yes**

Include previous mammograms, ultrasounds, CA125, MRIs

Interpreter needed:
☐ **No** ☐ **Yes**
Language: ______________

Referrals must meet one of the following referral criteria (*please check the box that applies)*:

☐ Family history of multiple cases of breast cancer (particularly when diagnosed < 50) and/or ovarian cancer (at any age) on the same side of the family – especially in close relatives over more than one generation
☐ Family history or personal history of breast cancer <35 years old
☐ Family history or personal history of ovarian cancer
☐ Family history or personal history of both breast and ovarian cancer
☐ Breast and/or ovarian cancer in Ashkenazi Jewish families
☐ Family history or personal history of bilateral breast cancer, especially if one or both was diagnosed <50
☐ Family history or personal history of male breast cancer
☐ Family member with BRCA1 or BRCA2 mutation, please specify: ______________

Comments:____________________

****Referrals that do not meet referral criteria will be declined****

Referrals for other hereditary cancer syndromes can also be made to NYGH Genetics clinic. Please use general referral form.

REFERRING DOCTOR:______________ **Physician billing #:**______________

Address:____________________

Phone # ______________ **Private #**______________ **Fax #**______________

PLEASE NOTE:
★ **Incomplete or illegible referrals will be returned to your office**
★ **Most patients will be contacted directly by a mailed questionnaire**

Please fax to the Familial Breast and Ovarian Cancer Clinic at 416-756-6727

Genetics, 3rd Floor, South East Wing, 4001 Leslie Street Toronto, Ontario M2K 1E1
Tel: 416-756-6345 Fax: 416-756-6727 www.nygh.on.ca

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