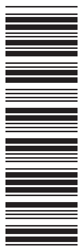

NORTH YORK GENERAL
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NAPBC NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS ACCREDITED BREAST CENTER | A QUALITY PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS

Breast Diagnostic Clinic (BDC) REFERRAL FORM

FORM SF0075 Page 1 of 1 Rev. 11/2024

Patient LABEL / Identification Area

All reports MUST be attached to referral for appointment to be made, including:

- ✓ Diagnostic reports from the past 5 years (mammogram, US, MRI, pathology, etc.)
- ✓ Past Medical History/medication or CPP (cumulative patient profile)

NOTE: MISSING INFORMATION WILL RESULT IN RETURN OF REFERRAL AND DELAYED APPOINTMENT

FAX #: 416-756-5986

Patient Information

Name: ______________________ Health Card # ______________________

Date of Birth (M/D/Y)______________ Gender: ☐ M ☐ F Phone #:______________

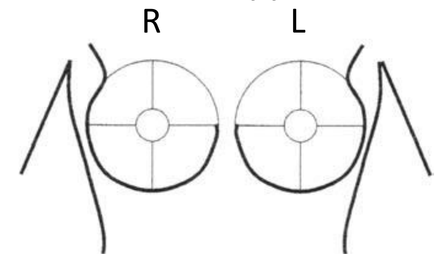
Address: ______________________ City/Town: ______________ Postal Code: __________

Reason for Referral

Clinical Abnormalities (check all that apply) :

☐ Suspicious mass (☐ palpable / ☐ non-palpable)
☐ Nipple discharge (☐ bloody / ☐ clear / ☐ unilateral / ☐ bilateral)
☐ Nipple inversion
☐ Skin changes
☐ Abnormal Imaging ☐ Abnormal Pathology
Other comments: ______________________________________
____

Please mark area(s) of concern:



☐ Right ☐ Left

Family or Personal History

☐ Family/Personal History of a BRCA1 or BRCA2 mutation
☐ Family History of breast and/or ovarian cancer: specify ______________________
☐ Personal History of breast and/or ovarian cancer: specify______________________
☐ Radiation before age 30

Referring Physician Information (or stamp)

Name: ______________________

Address: ______________________

Phone: ____________ Fax: ____________

Billing #: ______________________

Primary Care Physician Information

☐ N/A: same as referring physician

Name: ______________________

Address: ______________________

Phone:______________Fax: __________

Billing #: ______________________

☐ Referral to BDC Surgeon: Dr: ______________________ or ☐ Earliest available appointment

By completing this referral, I the referring practitioner hereby consent to any additional breast imaging (e.g. mammography, ultrasound) and/or biopsies that may be required.
Referring Practitioner Signature: ______________________ Date: ______________

Internal Use

Date Received **Referral to: BC ICC** ☐ **Medical Imaging** ☐

Approved By: Manager, BDC Approval Date: **Nov/2024**

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Contact #: 416-756-6816 | Email: bdc@nygh.on.ca