Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Patient Label

BREAST HEALTH CLINIC

Patient Referral Form

Phone: 905-883-1212 Ext. 3245 **Fax:** 905-883-0772

****Referring MD, please note sending this referral will assume you support proceeding with all necessary imaging and/or biopsy recommended for a full workup. "Important" please inform patient to provide medical breast images to our Breast Health Clinic prior to their appointment.**

Patient Information

Last Name: _____ First Name: _____

Street: *Apt:* *City/Town* *Province* *Postal Code*

Address: _____

Home Number: _____ Business Number: _____ Other: _____

Date of Birth _____ (dd/mm/yyyy)

Health Card Number: _____ Version Code: _____

Referring Physician Information

Referring Physician: _____ Referral Billing Number: _____

Street: *Apt:* *City/Town* *Province* *Postal Code*

Address: _____

Office Number: _____ Fax: _____

Reason for Referral

Right Breast ☐ Left Breast ☐ Breast Location: _____

Palpable Abnormality ☐ Yes ☐ No

Abnormal Mammogram ☐ Yes ☐ No

Abnormal Ultrasound ☐ Yes ☐ No

If no above, reason for referral? _____

Is patient aware of reason for referral? ☐ Yes ☐ No

Please list or attach a cumulative patient profile

Medications

Aspirin ☐ Yes ☐ No

Plavix ☐ Yes ☐ No

Coumadin ☐ Yes ☐ No

Other_____

Allergies _____

☐ No Known Allergies

Latex ☐ Yes ☐ No

Anaesthetic ☐ Yes ☐ No

Other _____

Additional Section

Please advise patients to bring all outside Mammography and Ultrasound Images to their clinic appointment.

Mammography Report Attached _____ Study Date: _____(dd/mm/yyyy)

Ultrasound Report Attached _____ Study Date: _____(dd/mm/yyyy)

Appointment Information

Mackenzie Health will notify patient of appointment date and time.