Breast Health Program Referral
BC Women's Hospital & Health Centre

4500 Oak Street, Vancouver, BC V6H 3N1
Tel: 604-875-3705 Fax: 604-875-3080

BC WOMEN'S HOSPITAL+ HEALTH CENTRE

- **Please remember to fax all relevant information with this referral form.**
- **We will contact your patient directly with an appointment time unless otherwise directed.**
- **Please list your phone and fax # at the bottom of this page for any future communications**

Patient Information *(MUST BE AS APPEARS ON BC I.D.)*

Surname	**First & Middle Names**	**PHN**	**DOB** _____/_____/_____ dd mm yr
Street Address	**City**	**Province**	**Postal Code**
***Home Tel**	***Work Tel**	***Cell Tel**	

*Please circle if patient has a preferred telephone contact number ***Interpreter needed*** ☐ ***Language***_____

Reason for Referral:

☐ **Abnormal SMP Exam #**

☐ **Physical Signs of New Abnormality**

(check all that apply)

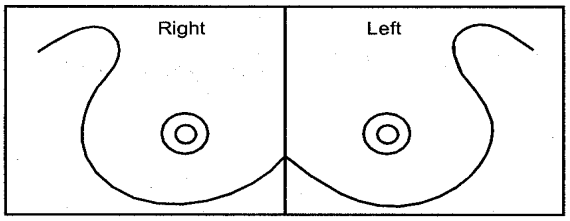
- ○ Lump
- ○ Thickening
- ○ Dimpling, contour deformity
- ○ Nipple discharge

☐ **Review of Outside Imaging for:**

- ○ Stereo Biopsy **–as recommended by Radiologist or Surgeon only**

☐ **Other**

Please indicate location of abnormality
If there has been a previous biopsy, please note scar on the diagram and send pathology report



☐ *Implants* ☐ *Wheelchair*

Referrals cannot be processed without completion of the following section. Please list ALL relevant breast imaging exams and procedures or indicate if no such imaging has been performed.

Procedures: Mammograms (Screening or Diagnostic), Ultrasound, Biopsies/Pathology Reports	**Date performed**	**Name of outside facility**
1)		
2)		
3)		

Referring MD	**Practice/Billing #**	**PHONE #**	**FAX #**
Family Physician (if different than above)		**Phone #**	**Fax #**
Referring Physician's Signature		**Date**	