

Medical Arts Building

581 Davis Drive, 3rd Floor
Newmarket, ON L3Y 2P6

Tel: 905-895-4521, ext. 2960
Fax (905) 952-2819

Diagnostic Assessment Unit

Health Record #: _____	Complete or place patient label here	
Patient Name: <i>(Print first, last)</i> _____		
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____	<input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____	
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>	

Breast Clinic - Physician Referral

Please fax to 905-952-2819

Patient Address: _____

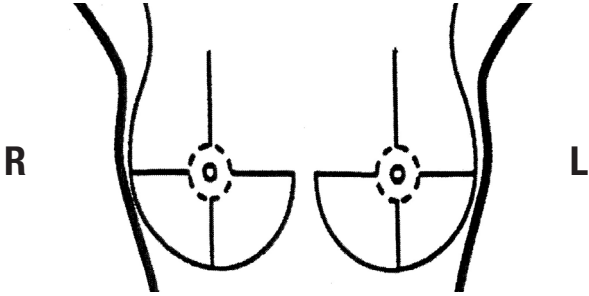
Patient Phone Number: _____	Patient Alternate Phone Number: _____
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Primary Care Physician Name: *(if different from referring Physician) (print first, last)* _____

REASON FOR REFERRAL:

Abnormal Imaging: SRHC Outside - reports must be attached
 Concerning Physical Findings: No imaging ordered SRHC imaging done SRHC imaging scheduled

Details: _____



SIGNIFICANT MEDICAL HISTORY:

MEDICATIONS: Coumadin

Others: _____

Comments: _____

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: <i>(print first, last)</i> _____	Billing #: _____
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Referring Physician Signature: _____	Date: <u>dd</u> / <u>mm</u> / <u>yy</u>
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Phone Number: _____	Fax Number: _____
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CLINIC USE ONLY

Date referral received: <u>dd</u> / <u>mm</u> / <u>yy</u>	APPOINTMENT - Date: <u>dd</u> / <u>mm</u> / <u>yy</u>	Time: _____
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