SOUTHLAKE
REGIONAL HEALTH CENTRE

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: *(Print first, last)* _____
DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Account #: _____ Date of Admission: dd / mm / yy

Breast Clinic - Physician Referral

Please fax to 905-952-2819

Patient Address:

Patient Phone Number: | **Patient Alternate Phone Number:**

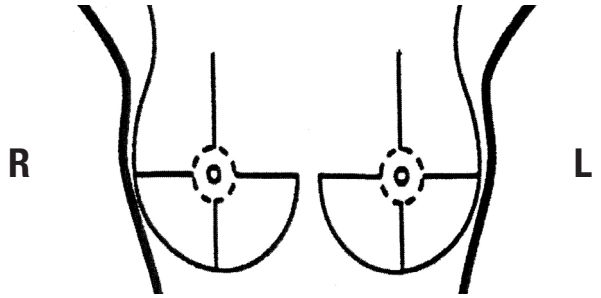
Primary Care Physician Name: *(if different from referring Physician) (print first, last)*

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, the referring physician confirms that this patient is aware of this referral. The referring physician also supports the Breast DAU team in ordering any additional imaging as needed (breast ultrasound, breast mammogram, and/or breast biopsy).

Referring Physician Name: *(print first, last)* | **Billing #:**

Referring Physician Signature: | **Date:** dd / mm / yy

Phone Number: | **Fax Number:**

CLINIC USE ONLY

Date referral received: dd / mm / yy | **APPOINTMENT – Date:** dd / mm / yy **Time:** _____

S-BRECPR