REQUEST FOR CONSULTATION
BREAST HEALTH CENTRE

HUMBER RIVER HOSPITAL

Wilson Avenue Site
1235 Wilson Avenue, 2nd Floor
Toronto, ON M3M 0B2
TEL. (416) 242-1000 EXT 63603

FAX REQUEST TO (416) 242-1055

Health Card No. _____

Last Name _____

First Name _____

❑ M ❑ F

Date of Birth (d/m/y) _____

Address _____

_____

Phone _____

Dr. E. Gebrechristos, Dr. A. Iskander, Dr. H. Sohi, Dr. J. Tan, Dr. L. Whiteacre

REFER THIS PATIENT TO:

❑ 1ST Available Surgeon or to Dr. _____ MD.
Please Specify

Patient must bring all relevant images, CDs, X-ray films, and reports to this appointment.

REASON FOR REFERRAL:

- ❑ Imaging Abnormality
- ❑ Abnormal Breast Exam

  Specify: _____
- ❑ Nipple Discharge
- ❑ Breast Pain or Tenderness
- ❑ Other - Please Specify Below

REFERRING PHYSICIAN'S INFORMATION

Physician's Name _____

Address _____

Phone _____

Fax _____

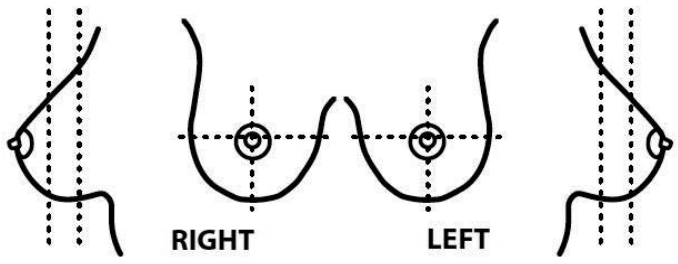
Physician's Signature × _____

DEPARTMENT USE ONLY

Appointment Date: _____

Appointment Time: _____

Mark All Areas of Concern



INCOMPLETE, ILLEGIBLE, AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED

Form # 100105, version (06-2018)

10060000006