Request for Breast Health Consult

Humber River Hospital
1235 Wilson Ave. **LEVEL 2 EAST**
Toronto, ON M3M 0B2
Phone 416-242-1000 Ext. 63601 ***Fax*** 416-242-1055

Appointment Information

Date ____________________ **Time** ____________________

Patient Information

Name ______________________________

OHIP # ____________________ VC __________

DOB (d/m/y) ____________________ Sex ☐ M ☐ F

Address ______________________________

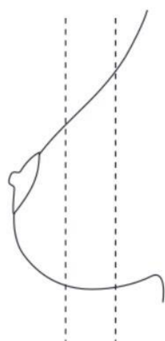
City ____________________ PC __________

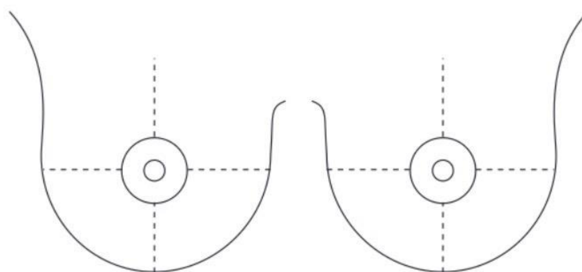
Phone ______________________________

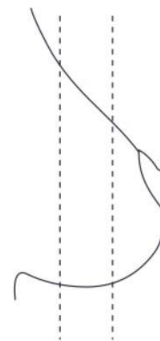
Dr. L. Whiteacre **Dr. J. Tan** **Dr. H. Sohi** **Dr. A. Iskander** **Dr. E. Gebrechristos**

☐ Please refer patient to 1st available Surgeon	☐ Please refer patient to Dr. ______________________ MD
Reason for Referral ☐ Abnormal Breast Imaging Findings ☐ Abnormal Physical Breast Exam ☐ Breast Pain, Tenderness ☐ Nipple Discharge ☐ Other ____________________	***Clinical Information***

Mark All Areas of Concern







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It is mandatory to bring all relevant images on CD and/or X-Ray film, as well as any related medical reports to this appointment.	***Referring Doctor Information*** Name (PRINT) ____________________ Address ____________________ City ____________________ PC __________ Phone ____________________ Fax __________ Signature ____________________ CPSO # ____________________ Billing # __________

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED

Form # 100105, version (07-2019)