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

Humber River Hospital

Appointment Information

Date _____ **Time** _____

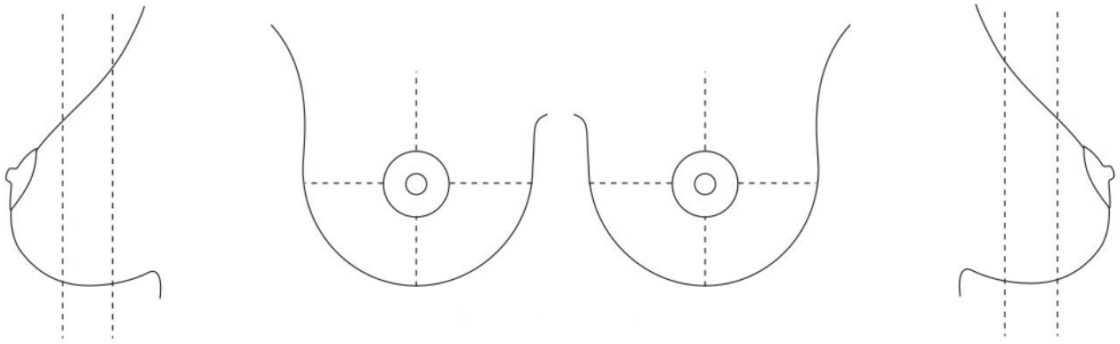
Patient Information

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** **Dr. M. Maggisano**

☐ 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



R **L**

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 (01-2021)

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