

Request for Breast Health Consult

Humber River Health
1235 Wilson Ave. **LEVEL 2 EAST**
Toronto, ON M3M 0B2



Phone 416-242-1000 Ext. 63601 **Fax** 1-855-932-1262

Appointment Information

Date _____ Time _____

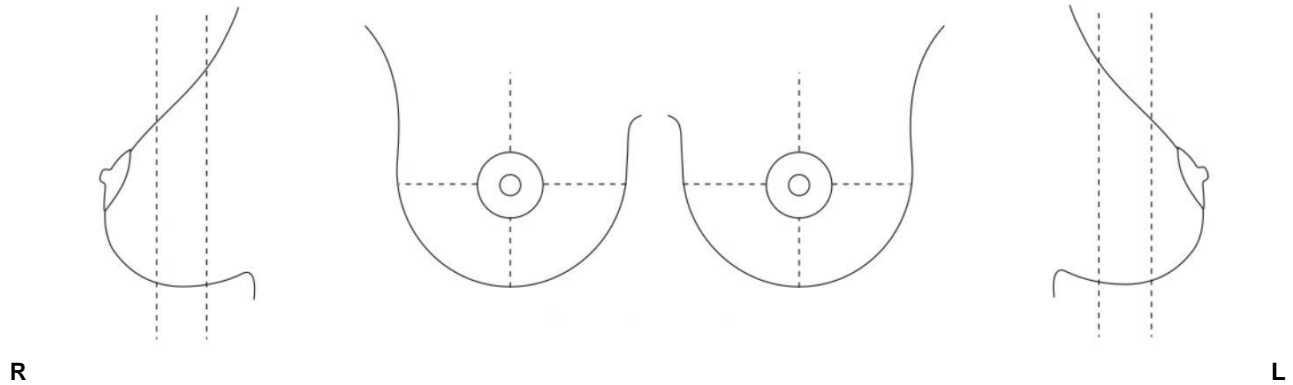
Patient Information

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

<input type="checkbox"/> Please refer patient to 1 st available Surgeon	<input type="checkbox"/> Please refer patient to Dr. _____ MD
Reason for Referral <input type="checkbox"/> Abnormal Breast Imaging Findings <input type="checkbox"/> Abnormal Physical Breast Exam <input type="checkbox"/> Breast Pain, Tenderness <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Other _____	Clinical Information

Mark All Areas of Concern



Form # 100105, version (01-2021)

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

