UHN Toronto General Toronto Western Princess Margaret Toronto Rehab

GATTUSO RAPID DIAGNOSTIC BREAST CENTRE / Referral Form

610 University Avenue,
Main Floor, Information Desk
Toronto, Ontario M5G 2M9
Telephone: 416-946-2297 Fax: 416-946-2370

GRDC # :	
MRN:	
Priority:	❑ **1** ❑ **2** ❑ **3**
Eligible:	❑ **Yes** ❑ **No**

Date Referral Faxed: _____/_____/_____
dd mm yy

Refer to:
❑ Next available Surgeon **OR** General Practice Oncologist
❑ Dr. T. Cil ❑ Dr. A. Easson ❑ Dr. J. Escallon
❑ Dr. W. Leong ❑ Dr. D. McCready ❑ Dr. M. Reedijk
❑ Dr. R. Heisey ❑ Dr. M. Wu ❑ Dr. K. Jang ❑ Dr. Shachar

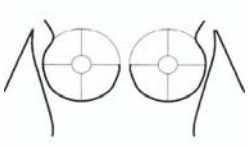
PATIENT INFORMATION

Place Patient stamp or sticker here if available

Last Name:
First Name:
Health Card #: VC.:
Date of Birth:
Address:
City: Province: Postal Code:
Phone # 1:
Phone # 2:
Phone # 3: Fluently in English: ❑ Yes ❑ No- Language:

REASON FOR REFERRAL (check all that apply)

❑ Abnormal Imaging (mammogram, ultrasound, MRI): * Date of previous mammogram:
* Location of previous mammogram:
❑ Palpable Lump: Location: o'clock: cm from nipple Size:
❑ Nipple Discharge
❑ Other/Additional Notes:



Medications:
Allergies:

REFERRING PHYSICIAN INFORMATION

Place Referring Physician stamp or sticker here if available

Referring Physician's Name:
Address:
Province: Postal Code Billing #:
Phone: Fax:
Family Physician:
(If different from Referring Physician)

……..
Referring Physician's Signature

For Rapid Diagnostic Centre Office Use Only

Previous GRDC: ❑ Yes ❑ No Referral Type: ❑ External ❑ Internal Referring Hospital: ❑ PMH ❑ WCH ❑ MSH ❑ TGH ❑ TWH ❑ N/A

Patient contacted for films:……..……..Date Images Received: ……..……Films sent to B.I.: ……...

Verbal Diagnosis Date:…… Abnormality first detected by:

Verbal Diagnosis Source: ❑ Phone ❑ Consult ❑ Self Breast Exam Date: ____/____/____ (dd/mm/yy)

Verbal Diagnosis Given by: ❑ Clinical Breast Exam Date: ____/____/____ (dd/mm/yy)

❑ NP ❑ GPO ❑ Surgeon ❑ FD ❑ Med Onc ❑ Radiological Exam Date: ____/____/____ (dd/mm/yy)

Blood Thinners: ❑ Yes ❑ No Name & Date last taken: ……..…… ……..……..……

Confirmed RDC Date with patient: ……..Confirmed F/U Date with patient: : ……

RDC Appointment:…….
(PMH, 3rd floor Breast Imaging, Room 935)

Follow-up Appointment:…….. with: ……..……
(2nd floor Breast Clinic PMH /12th floor MSH or WCH)

D6611