



SOUTH ISLAND INTEGRATED BREAST CANCER PROGRAM CENTRALIZED REFERRAL

IMPORTANT

Inclusion criteria: primary breast invasive or in-situ carcinoma, biopsy proven

- Invasive mammary carcinoma (ductal, lobular or other subtype)
- In situ breast carcinoma (DCIS, LCIS)
- Other breast malignancy (e.g. phyllodes tumor)

Please fill out the entire form and fax to number in the ROUTING section below.

PATIENT INFORMATION	REFERRER INFORMATION
Last name	Referring primary care provider
First name	MSP #
Date of birth <small>Month Day Year</small>	Clinic Name Street Address Phone
PHN	
Primary contact number	Primary care provider full name
Email address	<input type="checkbox"/> Same as ordering practitioner

REFERRAL INFORMATION

- Invasive mammary carcinoma (ductal, lobular or other subtype)
 In situ breast carcinoma (DCIS, LCIS)
 Other breast malignancy (e.g. phyllodes tumor)

Refer to <input type="checkbox"/> First Available Surgeon <input type="checkbox"/> Requested Surgeon (s) <input type="checkbox"/> Dr. Bradley Amson <input type="checkbox"/> Dr. Darren Biberdorf <input type="checkbox"/> Dr. Johann Cunningham <input type="checkbox"/> Dr. Heather Emmerton-Coughlin <input type="checkbox"/> Dr. Allen Hayashi <input type="checkbox"/> Dr. Mohammadali "Sohrab" Khorasani <input type="checkbox"/> Dr. Elaine Lam <input type="checkbox"/> Dr. Alison Ross <input type="checkbox"/> Dr. Bao Tang	Patient aware of cancer diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Site of malignancy <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral Suspect inflammatory <input type="checkbox"/> Yes <input type="checkbox"/> No Previous breast cancer <input type="checkbox"/> Yes <input type="checkbox"/> No 40 years of age or less <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate recent imaging performed: Mammogram <input type="checkbox"/> Yes <input type="checkbox"/> No Ultrasound <input type="checkbox"/> Yes <input type="checkbox"/> No Magnetic Resonance Imaging (MRI) <input type="checkbox"/> Yes <input type="checkbox"/> No <ul style="list-style-type: none"> Existing imaging results must be attached Please attach patient's medical history if available
--	--	---

ROUTING

FAX # 250-370-8102	Date referral sent <small>Month Day Year</small>	Total # of pages faxed		
ROUTING TO SURGEON OFFICE – This section to be completed by SI Integrated Breast Cancer Program				
Allocated surgeon	Date PCP confirmed referral <small>Month Day Year</small>	Tentative surgical date <small>Month Day Year</small>	Date referral faxed to surgeon <small>Month Day Year</small>	Total # of pages faxed
PCP / Patient decision if wait over benchmark (FNA, requested surgeon)		Wait time of initial requested surgeon (if over benchmark)		

*If you have questions or would like to suggest changes to this form, please contact
RegionalClinicalForms@viha.ca*