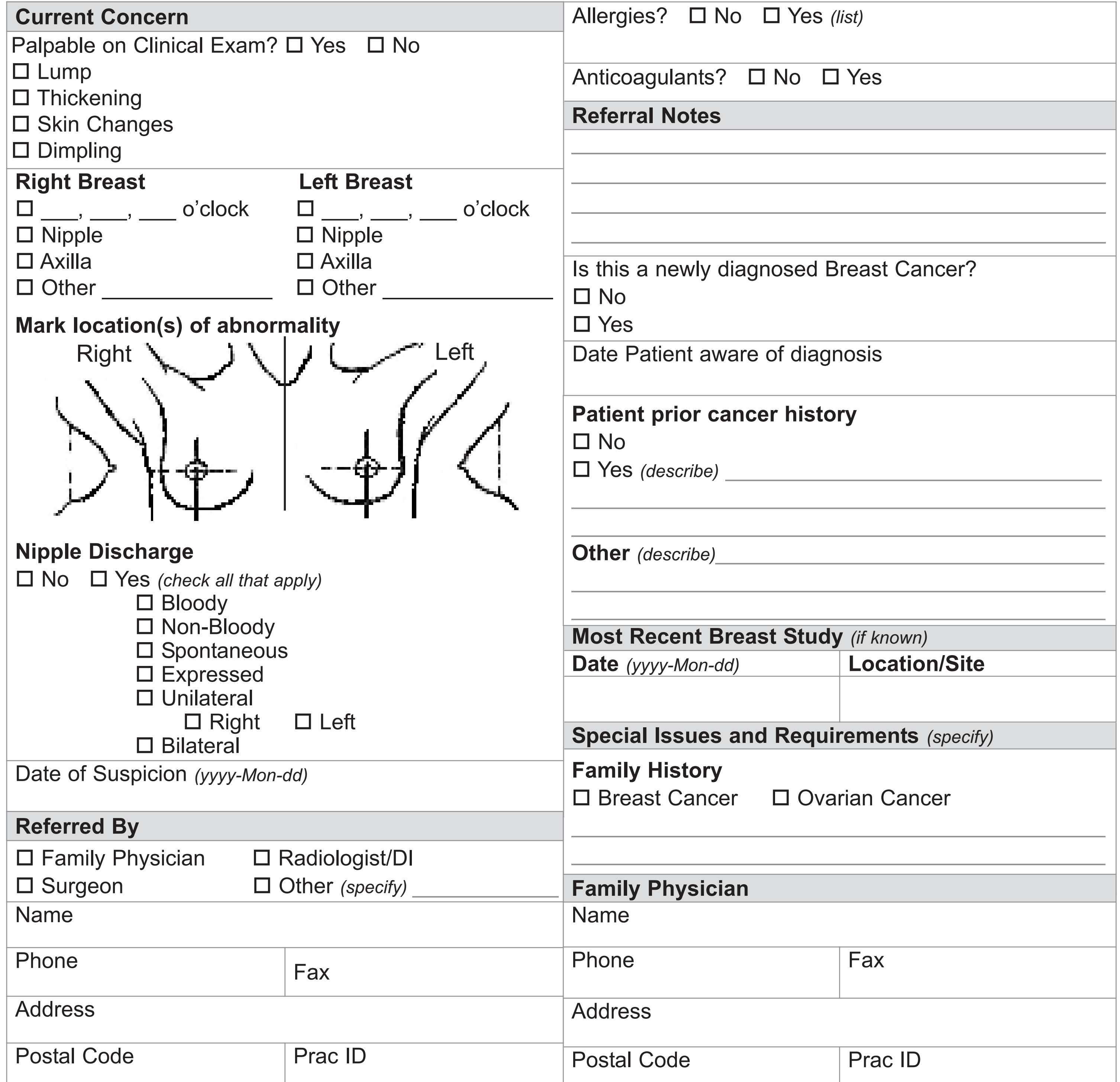
Alberta Health Services

Comprehensive Breast Care Program (CBCP) Referral

Fax Completed form to 780.643.4488 or phone 780.638.2227
Referrals will not be processed if form is incomplete

Referral criteria for the CBCP
- Strong Suspicion of Breast Cancer
- Newly diagnosed breast cancer
- Palpable lump on clinical exam and/or abnormality on Diagnostic Imaging

Name	
Address	
City	Postal Code
Phone	PHN
Birthdate	Gender ☐ Male ☐ Female



Current Concern

Palpable on Clinical Exam? ☐ Yes ☐ No
☐ Lump
☐ Thickening
☐ Skin Changes
☐ Dimpling

Right Breast
☐ ___, ___, ___ o'clock
☐ Nipple
☐ Axilla
☐ Other ______________

Left Breast
☐ ___, ___, ___ o'clock
☐ Nipple
☐ Axilla
☐ Other ______________

Mark location(s) of abnormality

Right Left

Nipple Discharge
☐ No ☐ Yes *(check all that apply)*
☐ Bloody
☐ Non-Bloody
☐ Spontaneous
☐ Expressed
☐ Unilateral
☐ Right ☐ Left
☐ Bilateral

Date of Suspicion *(yyyy-Mon-dd)*

Referred By

☐ Family Physician ☐ Radiologist/DI
☐ Surgeon ☐ Other *(specify)* ______________

Name	
Phone	Fax
Address	
Postal Code	Prac ID

Allergies? ☐ No ☐ Yes *(list)*

Anticoagulants? ☐ No ☐ Yes

Referral Notes

____
____
____
____

Is this a newly diagnosed Breast Cancer?
☐ No
☐ Yes

Date Patient aware of diagnosis

Patient prior cancer history
☐ No
☐ Yes *(describe)* ______________________________
____
____

Other *(describe)* ______________________________
____
____

Most Recent Breast Study *(if known)*

Date *(yyyy-Mon-dd)*	**Location/Site**

Special Issues and Requirements *(specify)*

Family History
☐ Breast Cancer ☐ Ovarian Cancer
____
____

Family Physician

Name	
Phone	Fax
Address	
Postal Code	Prac ID