

Comprehensive Breast Care Program (CBCP) Referral

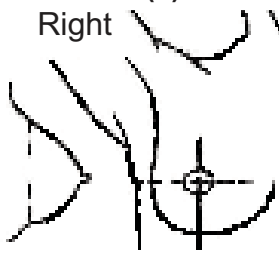
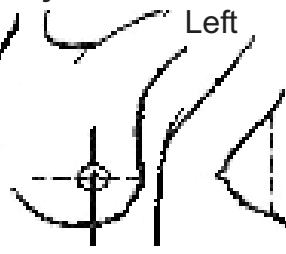
Fax Completed form to 780.641.9523 or phone 780.613.5090

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
- Physical/history required

Name	
Address	
City	Postal Code
Phone	PHN
Birthdate	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

Current Concern	Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (<i>list</i>)
Palpable on Clinical Exam? <input type="checkbox"/> Yes <input type="checkbox"/> No	Anticoagulants? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Lump	Referral Notes
<input type="checkbox"/> Thickening	
<input type="checkbox"/> Skin Changes	
<input type="checkbox"/> Dimpling	
Right Breast	
<input type="checkbox"/> ____, ____, ____ o'clock	
<input type="checkbox"/> Nipple	
<input type="checkbox"/> Axilla	
<input type="checkbox"/> Other _____	
Left Breast	
<input type="checkbox"/> ____, ____, ____ o'clock	
<input type="checkbox"/> Nipple	
<input type="checkbox"/> Axilla	
<input type="checkbox"/> Other _____	
Mark location(s) of abnormality	Is this a newly diagnosed Breast Cancer?
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Right</p>  </div> <div style="text-align: center;"> <p>Left</p>  </div> </div>	<input type="checkbox"/> No
	<input type="checkbox"/> Yes
	Date Patient aware of diagnosis
	Patient prior cancer history
	<input type="checkbox"/> No
	<input type="checkbox"/> Yes (<i>describe</i>) _____

	Other (<i>describe</i>) _____

	Most Recent Breast Study (<i>if known</i>)
	Date (yyyy-Mon-dd)
	Location/Site

	Special Issues and Requirements (<i>specify</i>)
	Family History
	<input type="checkbox"/> Breast Cancer <input type="checkbox"/> Ovarian Cancer

	Family Physician
	Name
	Phone
	Fax
	Address
	Postal Code
	Prac ID
Referred By	
<input type="checkbox"/> Family Physician	<input type="checkbox"/> Radiologist/DI
<input type="checkbox"/> Surgeon	<input type="checkbox"/> Other (<i>specify</i>) _____
Name	
Phone	Fax
Address	
Postal Code	Prac ID