SASKATOON HEALTH REGION
Saskatoon Saskatchewan
Saskatoon City Hospital

BREAST HEALTH PROGRAM
Irene & Leslie Dube Centre Of Care
701 Queen Street S7K 0M7
(T) 655-8686 (F) 655-7740

REFERRAL FORM (FAX TO 655-7740)

PATIENT NAME & CONTACT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY		POSTAL CODE
PHONE (PRIMARY)		PHONE (SECONDARY)		
BIRTH DATE (M/D/YY)	AGE	GENDER ☐ M ☐ F	HSN	

REFERRING PHYSICIAN

NAME		
ADDRESS	CITY	POSTAL CODE
PHONE	FAX	

FAMILY PHYSICIAN

NAME		
ADDRESS	CITY	POSTAL CODE
PHONE	FAX	

REASON FOR REFERRAL

____
____
____
____
____

MEDICAL HISTORY

Previous Breast Cancer (specify)

____
____
____
____

Anticoagulant (specify) ______________________

PREVIOUS IMAGING (Where & When)

Mammogram ______________________________

Ultrasound ______________________________

MRI ______________________________

Other ______________________________

REFERRED TO

☐ First Available Breast Surgeon
Or ☐ Breast Surgeon of choice (name) ______________________

☐ Already has referral to a breast surgeon in another health region

☐ Breast Cancer Reconstruction
☐ First Available Plastic Surgeon or ☐ Plastic Surgeon of Choice (name) __________________________

☐ High Risk Breast Cancer Clinic Referral (Indications: Strong family history of breast cancer, male breast cancer or ovarian cancer; chest radiation; high risk benign pathology; LCIS; atypical hyperplasia (ALH or ADH); BRCA 1/BRCA2 carrier or first degree relative with a BRCA 1 or BRCA2.

REFERRING PHYSICIAN SIGNATURE

NAME	DATE