

## Comprehensive Breast Care Program (CBCP) Referral

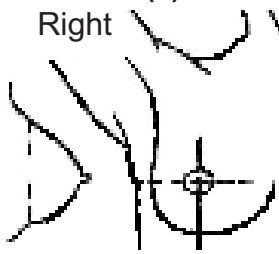
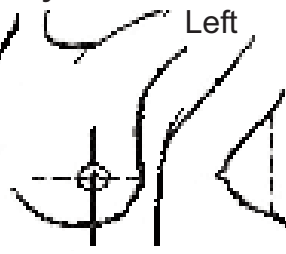
Fax Completed form to **780-641-9523** or phone 780-613-5090

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

<b>Current Concern</b>		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 <input type="checkbox"/> Thickening <input type="checkbox"/> Skin Changes <input type="checkbox"/> Dimpling		<b>Referral Notes</b>					
<b>Right Breast</b> <input type="checkbox"/> ____, ____, ____ o'clock <input type="checkbox"/> Nipple <input type="checkbox"/> Axilla <input type="checkbox"/> Other _____		<b>Left Breast</b> <input type="checkbox"/> ____, ____, ____ o'clock <input type="checkbox"/> Nipple <input type="checkbox"/> Axilla <input type="checkbox"/> Other _____					
<b>Mark location(s) of abnormality</b> <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>							
<b>Nipple Discharge</b> <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>check all that apply</i> )		Is this a newly diagnosed Breast Cancer? <input type="checkbox"/> No <input type="checkbox"/> Yes					
<input type="checkbox"/> Bloody <input type="checkbox"/> Non-Bloody <input type="checkbox"/> Spontaneous <input type="checkbox"/> Expressed <input type="checkbox"/> Unilateral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral		Date Patient aware of diagnosis _____					
Date of Suspicion ( <i>yyyy-Mon-dd</i> )		<b>Patient prior cancer history</b> <input type="checkbox"/> No <input type="checkbox"/> Yes ( <i>describe</i> ) _____					
<b>Referred By</b>		<b>Other</b> ( <i>describe</i> ) _____					
<input type="checkbox"/> Family Physician <input type="checkbox"/> Radiologist/DI <input type="checkbox"/> Surgeon <input type="checkbox"/> Other ( <i>specify</i> ) _____		<b>Most Recent Breast Study</b> ( <i>if known</i> )					
Name		<table border="1" style="width: 100%;"> <tr> <th>Date (<i>yyyy-Mon-dd</i>)</th> <th>Location/Site</th> </tr> <tr> <td> </td> <td> </td> </tr> </table>		Date ( <i>yyyy-Mon-dd</i> )	Location/Site		
Date ( <i>yyyy-Mon-dd</i> )	Location/Site						
Phone		<b>Special Issues and Requirements</b> ( <i>specify</i> )					
Fax		<b>Family History</b> <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Ovarian Cancer					
Address		<b>Family Physician</b>					
Postal Code		Name					
Prac ID		Phone					
		Fax					
		Address					
		Postal Code					
		Prac ID					