University Health Network
Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital

GATTUSO RAPID DIAGNOSTIC BREAST CENTRE / Referral Form

610 University Avenue 3rd Floor Room 3-130
Toronto, Ontario M5G 2M9
Telephone: 416-946-2297

GRDC # :	
MRN:	
Referral Rec'd:	
Priority:	❑ 1 ❑ 2 ❑ 3
Eligible:	❑ Yes ❑ No

*** Fax referral form along with breast imaging reports to 416-946-2370. Patient will be contacted with appointment and a confirmatory fax sent to you.**

Date Referral Faxed: _____/_____/_____
dd mm yy

Refer to: ❑ Next available Surgeon **OR**
❑ Dr. T. Cil ❑ Dr. A. Easson ❑ Dr. J. Escallon
❑ Dr. W. Leong ❑ Dr. D. McCready ❑ Dr. M. Reedijk
❑ Dr. R. Heisey, G.P. Oncologist

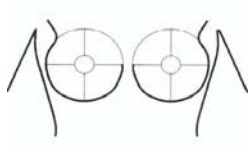
PATIENT INFORMATION

Place Patient stamp or sticker here if available

Last Name:
First Name:
Health Card #: VC.:
Date of Birth:
Address:
City: Province: Postal Code:
Phone # 1:
Phone # 2:
Phone # 3:
Fluently in English: ❑ Yes ❑ No- Language:

REASON FOR REFERRAL (check all that apply)

❑ Abnormal Imaging (mammogram, ultrasound, MRI): ∗ Date of previous mammogram:
∗ Location of previous mammogram:
❑ Palpable Lump: Location: o'clock: cm from nipple Size:
❑ Nipple Discharge
❑ Other/Additional Notes:



Medications:
Allergies:

REFERRING PHYSICIAN INFORMATION

Place Referring Physician stamp or sticker here if available

Referring Physician's Name:
Address:
Province: Postal Code Billing #:
Phone: Fax:
Family Physician:
(If different from Referring Physician)

……..
Referring Physician's Signature

For Rapid Diagnostic Centre Office Use Only

Previous GRDC: ❑ Yes ❑ No Referral Type: ❑ External ❑ Internal Orders entered:……..……..…
Patient contacted for films:……..……..Date Images Received: ……..……Films sent to B.I.: ……...
Verbal Diagnosis Date:…… Abnormality first detected by:
Verbal Diagnosis Source: ❑ Phone ❑ Consult ❑ Self Breast Exam Date: ____/____/____ (dd/mm/yy)
Verbal Diagnosis Given by: ❑ Clinical Breast Exam Date: ____/____/____ (dd/mm/yy)
❑ NP ❑ GPO ❑ Surgeon ❑ FD ❑ Radiological Exam Date: ____/____/____ (dd/mm/yy)
❑ Not Documented

Blood Thinners: ❑ Yes ❑ No Date last taken:……..……..……
Confirmed RDC Date with patient: ……Confirmed F/U Date with patient: : ……

RDC Appointment:……..……..
(PMH, 3rd floor Breast Imaging, Room 935)

Follow-up Appointment:…….. with Dr.: ……..……
(2nd floor Breast Clinic PMH or 12th floor MSH)

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