MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Michael Garron Hospital – Breast Diagnostic Clinic

Request for Radiology and Surgery Consultation

Fax: (416) 469-6154 **Tel: (416) 469-6580 x 2749**

Surname	Given Name	Birth Date dd/mm/yy	Gender M ☐ F ☐
Street	City	Postal Code	MRN
Home Phone ( )	Work ( )	OHIP Number	VC
Primary Contact Surname	Primary Contact Given Name	Home ( )	Relationship

Referring Physician Name	Physician Number	Date of Referral
Date of Suspicious Findings(dd/mm/yyy)_____		

Reason for Referral:

- ☐ Palpable Breast Lump
- ☐ Suspicious Mammogram/Ultrasound
- ☐ Drainage from Nipple
- ☐ Abnormal/Change in Breast Appearance
- ☐ Other (Please specify) _____

Has a Mammogram/Ultrasound been done? Y N (If yes please send films with patient)

INTERNAL USE ONLY

	Consult Date	Consult Time
Surgeon Dr._____		
Follow-up		

INVESTIGATIONS BOOKED

		Date Confirmed	Time Confirmed
Radiology	☐ Mammogram		
	☐ Ultrasound		
	☐ MRI		
Surgery	☐ FNA		
	☐ Stereotactic Biopsy		
	☐ Core Biopsy		
Post Diagnostic Findings	☐ Surgery_____		
	☐ Multi-Disciplinary Tumor Board		
	☐ Medical Oncologist_____		
	☐ Radiation Oncologist_____		
	☐ Plastic Surgeon_____		
	☐ Social Support		