# SOUTH ISLAND INTEGRATED BREAST CANCER PROGRAM CENTRALIZED REFERRAL

island health

## IMPORTANT

Inclusion criteria: primary breast invasive or in-situ carcinoma, biopsy proven. Patient MUST be aware of diagnosis

- Invasive mammary carcinoma (ductal, lobular or other subtype)
- In situ breast carcinoma (DCIS, LCIS)
- Other breast malignancy (e.g. phyllodes tumor)

**Please fill out the entire form and fax to number in the ROUTING section below.**

| PATIENT INFORMATION | REFERRER INFORMATION |
|---|---|
| Last name | Referring primary care provider |
| First name | MSP # |
| Date of birth Month Day Year | Clinic Name<br>Street Address<br>Phone STAMP |
| PHN | |
| Primary contact number | Primary care provider full name |
| Email address | ☐ Same as ordering practitioner |

## REFERRAL INFORMATION

☐ Invasive mammary carcinoma (ductal, lobular or other subtype)

☐ In situ breast carcinoma (DCIS, LCIS)

☐ Other breast malignancy (e.g. phyllodes tumor)

Refer to

☐ **First Available Surgeon**

☐ Requested Surgeon (s)

- ☐ Dr. Bradley Amson
- ☐ Dr. Darren Biberdorf
- ☐ Dr. Johann Cunningham
- ☐ Dr. Heather Emmerton-Coughlin
- ☐ Dr. Allen Hayashi
- ☐ Dr. Mohammadali "Sohrab" Khorasani
- ☐ Dr. Elaine Lam
- ☐ Dr. Alison Ross
- ☐ Dr. Bao Tang

Date patient informed of cancer diagnosis:
Month Day Year

Site of malignancy
☐ Left ☐ Right ☐ Bilateral

Suspect inflammatory
☐ Yes ☐ No

Previous breast cancer
☐ Yes ☐ No

40 years of age or less
☐ Yes ☐ No

Pregnant
☐ Yes ☐ No

Indicate recent imaging performed:

Mammogram
☐ Yes ☐ No

Ultrasound
☐ Yes ☐ No

Magnetic Resonance Imaging (MRI)
☐ Yes ☐ No

- **Existing imaging results must be attached**
- Please attach patient's medical history if available

## ROUTING

| **FAX # 250-370-8102** | Date referral sent Month Day Year | Total # of pages faxed |
|---|---|---|

**ROUTING TO SURGEON OFFICE – *This section to be completed by SI Integrated Breast Cancer Program***

| Allocated surgeon | Date PCP confirmed referral Month Day Year | Tentative surgical date Month Day Year | Date referral faxed to surgeon Month Day Year | Total # of pages faxed |
|---|---|---|---|---|
| | | | | |

| PCP / Patient decision if wait over benchmark (FNA, requested surgeon) | Wait time of initial requested surgeon (if over benchmark) |
|---|---|
| | |

*If you have questions or would like to suggest changes to this form, please contact RegionalClinicalForms@viha.ca*