Alberta Health Services

Name	
Address	
City	Postal Code
Phone	PHN
Birthdate	Gender ☐ Male ☐ Female

Comprehensive Breast Care Program (CBCP) Referral

Fax Completed form to 780.643.4488 or phone 780.638.2227

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

Requests for High Risk Assessment: Contact the Hereditary Breast & Ovarian Clinic by fax 780.735.5611

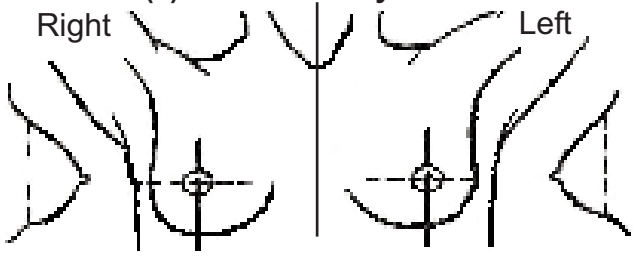
Current Concern

Palpable on Clinical Exam? ☐ Yes ☐ No
- ☐ Lump
- ☐ Thickening
- ☐ Skin Changes
- ☐ Dimpling

Right Breast
- ☐ ___, ___, ___ o'clock
- ☐ Nipple
- ☐ Axilla
- ☐ Other _____

Left Breast
- ☐ ___, ___, ___ o'clock
- ☐ Nipple
- ☐ Axilla
- ☐ Other _____

Mark location(s) of abnormality



Nipple Discharge

☐ No ☐ Yes *(check all that apply)*
- ☐ Bloody
- ☐ Non-Bloody
- ☐ Spontaneous
- ☐ Expressed
- ☐ Unilateral
  - ☐ Right ☐ Left
- ☐ Bilateral

Date of Suspicion *(yyyy-Mon-dd)*

Referred By

☐ Family Physician ☐ Radiologist/DI
☐ Surgeon ☐ Other *(specify)* _____

Name	
Phone	Fax
Address	
Postal Code	Prac ID

Referral Notes

Is this a newly diagnosed Breast Cancer?

☐ No
☐ Yes

Date Patient aware of diagnosis

Patient prior cancer history

☐ No
☐ Yes *(describe)* _____

Other *(describe)* _____

Most Recent Breast Study *(if known)*

Date *(yyyy-Mon-dd)*	**Location/Site**

Special Issues and Requirements *(specify)*

Family History

☐ Breast Cancer ☐ Ovarian Cancer

Family Physician

Name	
Phone	Fax
Address	
Postal Code	Prac ID