Hôpital Montfort
713, chemin Montréal Road
Ottawa, Ontario K1K 0T2
(613) 746-4621 ext. 4374
Fax : 613-748-4958

BREAST CLINIC
Consultation request

Montfort Hospital unique chart number if available: ____________

Name: ____________

Address: ____________

Sex: ☐ F ☐ M DOB: ______/______/______

Tel. Home : ____________

OHIP #____________ Version ______

Work : ____________ **Cell :** ____________

REFERRING PHYSICIAN INFORMATION

Name: ____________ Billing #: ____________

Address: ____________

Tel.: ____________ Fax: ____________

Consent:
By referring, I accept the radiologist's recommendations and requests of the diagnostic exams (as per below mentioned criterias) before the consultation with the surgeon.

☐ **Yes** ☐ **No, I will request the diagnostic investigations**

Signature: ____________ Date: ______/______/______

Please check the reason/s for your consultation request

Criterias for eligibility		**Requests for diagnostic exams (Section reserved for Hospital)**
☐ Birads 6 - Proven breast cancer ☐ Birads 5 - Cancer until proven otherwise	➔	1. Biopsy (Birads 5) 2. Referral to thrombosis clinic if applicable ** **Unless otherwise advised by surgeon** **
☐ Suspicious lump	➔	Mammography if not done within previous year and ultrasound of affected breast
☐ Birads 4 - Radiological investigation suggested	➔	Ultrasound, biopsy as suggested by radiologist.
☐ Palpable axillary lymph nodes	➔	Mammography and ultrasound of breasts and axilia if not done in previous 6 months
☐ Previous breast cancer	➔	Mammography if not done within previous year
☐ Spontaneous inverted nipple/skin, redness, orange peel	➔	Mammography and ultrasound of affected breast
☐ Bloody nipple discharge	➔	Mammography and ultrasound of affected breast
☐ High risk family history	➔	Mammography if not done within previous year

Please fax us the following documents and reports to 613-748-4958

- Allergies
- Medication list
- Créatinine (≤ 3 months)
- All pertinent diagnostic imaging reports
- Medical History / Profile

Comments:

____

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TRIAGE (Section reserved for administration)

Appointment with registered nurse ☐ Yes ☐ No

Appointment with surgeon ☐ Yes ☐ No If yes ☐ Urgent ☐ Non urgent

If urgent booking – Appointment date: ______/______/______

R.N.'s signature : ____________ Date: ______/______/______