Vancouver Coastal Health Breast Reconstruction Network

Breast Reconstruction Referral

Fax: 604-877-8538 **Phone: 604-877-8361 or 1-866-477-8361 (toll-free)**

Date sent: _____

Reason for Consultation: ☐ Newly diagnosed breast cancer* ☐ Other types of immediate breast reconstruction (gene positivity, etc.)*
☐ Recurrence ☐ Delayed breast reconstruction ☐ Breast reconstruction revision ☐ Partial breast reconstruction ☐ Second opinion
☐ Other: _____

*Referral requests for immediate reconstruction must have a completed general surgeon consult before referral to a plastic surgeon

REFERRING PROVIDER DETAILS

☐ Family Physician ☐ General Surgeon ☐ Other:

Physician Name:	Physician Billing Number:	Physician Phone:	Physician Fax:

PATIENT INFORMATION

First Name:	Last Name:	Date of Birth (dd/mm/yyyy):	Gender:

PHN #:	**Height:**	**Weight:**	**BMI:**	**Smoker?** ☐ Yes ☐ No

Street Address:	City:	Province:	Postal code:

Phone (Home/Cell/Work):	Phone (Home/Cell/Work):	Email Address:

Alternate Contact Name:	Relationship:	Phone (Home/Cell):

If not referred by Family Physician:	Family Physician Name:	Family Physician Phone:	Family Physician Fax:

REFERRED TO

☐ Central Intake for Breast Reconstruction (First available Surgeon)

☐ Specific Surgeon/Site Specify: _____

Reason for specific referral: _____

CLINICAL INFORMATION REQUIRED (Fax copies of all consultation/clinical notes & reports)

Any other specialists involved? ☐ No
☐ General Surgery (if referred by family physician)
Name: _____
☐ Medical Oncology
Name: _____
☐ Radiation Oncology
Name: _____
☐ Other
Name: _____

Diagnosis:
_____

Patient Informed of Diagnosis?
☐ Yes ☐ No

Interpreter Required for Consult?
☐ No
☐ Yes: please specify patient's primary language:
_____

Diagnostic Imaging/Reports:
☐ Breast Imaging *(Mammogram, MRI, Ultrasound)*
☐ OR notes
☐ Pathology
☐ Other_____

Estimated end date of adjuvant treatment:
_____

REFERRING PHYSICIAN CHECKLIST FOR A COMPLETE REFERRAL

☐ Referral letter/Consult note including list of all medications ☐ Pathology reports ☐ Surgical procedure notes
☐ Diagnostic imaging reports

OFFICE USE ONLY

Date Received:	Next Available Surgery Date & Time:	Surgeon:	☐ Faxed to Surgeon	Date Received:

☐ Consult Booked	Consult Date:	☐ Surgery Date Confirmed	Surgery Date:

Date Patient Contacted:	Date Referring Physician Notified: