Alberta Health Services

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

Comprehensive Breast Care Program (CBCP) Referral

Fax Completed form to 780-641-9523 or phone 780-613-5090
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
- Physical/History required

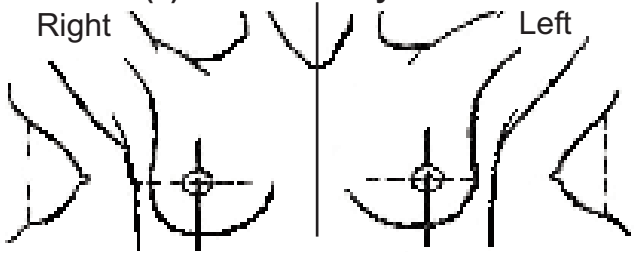
Current Concern

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

Allergies? ☐ No ☐ Yes *(list)*

Anticoagulants? ☐ No ☐ Yes

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