



BREAST – SURGICAL ONCOLOGY REFERRAL FORM

FOR URGENT REFERRALS CONTACT PHYSICIAN DIRECTLY

1266 – 600 University Avenue
Toronto, Ontario, Canada M5G 1X5
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Please indicate if you would like an appointment with the next available surgeon or a specific surgeon:

- BREAST**
- Next available OR Dr. Andrea Covelli Phone: 416-586-4800 ext. 5163 Fax: 416-586-8847
- Fax: 416-586-8847 Dr. Alexandra Easson Phone: 416-586-4800 ext. 2775 Fax: 416-586-8847
- Dr. Jaime Escallon Phone: 416-586-4800 ext. 5163 Fax: 416-586-8847
- Dr. Wey Leong Phone: 416-946-2992 Fax: 416-946-4429
- PLASTIC RECONSTRUCTION SURGERY Phone: 416-340-3143 Fax: 416-340-4403
- Dr. Anne O'Neill

PATIENT INFORMATION

Last name:		First name:		Date of Birth: (YYYY MM DD)	
Health card #			Version:		
Street Address:		City:		Province:	Postal Code:
Best phone:			Alternative phone:		
Interpreter services required:			Any special physical needs:		

* REQUIRED CLINICAL INFORMATION *

Please include all relevant information and FAX appropriate clinical notes and reports. **CHECK LIST** provided below

- Pathology reports Most recent clinic/consult note
- Tumour marker reports Diagnostic imaging reports

****PATIENT MUST BRING ALL IMAGES ON A CD / OR DIGITAL ACCESS CODE****

Reason for consultation:	Diagnosis:
	Has the patient been informed of Diagnosis? <input type="checkbox"/> YES <input type="checkbox"/> NO

REFERRING PHYSICIAN INFORMATION

Referring Physician:		Referral date:	
Billing#	Office Phone:	Fax:	
Office address:			