FAMILY MEDICINE REFERRAL TO BREAST CANCER SUPPORTIVE CARE

#414, 301-14 Street N.W., Calgary, Alberta T2N 2A1
Tel: 403-270-2242 |Fax: 403-270-2251 | www.bcscf.com

Date: _____

Referring Physician_____ PRAC ID_____
Patient Name_____ DOB (DD/MM/YY)_____
Address_____ PHC Number_____
Phone (H) _____(W)_____(C)_____

Patient Status:

- ☐ **Recently Diagnosed – no treatment yet**
- ☐ **Undergoing Treatment (Surgery / Chemo / Radiation)**
- ☐ **Post Treatment (possibly still Herceptin / Hormonal Therapy / Breast Reconstruction)**
- ☐ **Recurrence / Progression of Disease**
- ☐ **High Risk (Breast/ovarian cancer)**

Issues and Concerns:

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URGENCY of referral:

- ☐ Urgent – see within a week
- ☐ Semi urgent – see within a month
- ☐ Non urgent – see within 2-3 months

Please be advised we attempt to call this patient within one week to book an appointment. Thank you.