DO NOT PLACE LABEL ABOVE LINE

BC CANCER BREAST SCREENING
Provincial Health Services Authority

REFERRAL UPDATE FORM

AFFIX CLIENT LABEL HERE

PRESS FIRMLY TO ENSURE LEGIBILITY
FAX TO BREAST SCREENING PROGRAM: 1 (604) 708-2149

REFERRAL DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F|M|X) F

FACILITY NAME | AMENDED DATE (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD)

PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

COMPLETE ONLY ONE SECTION BELOW

☐ **SECTION A: TRANSFER REQUEST** *Complete only if referral requires a transfer to another facitlity.*

Transfer Request To: _____
(Name of Medical Imaging Facility or City)

Reason:
☐ Medical Reason
☐ Patient Preference
☐ Patient Address Related
☐ No Appointment Availability
☐ Requested Service(s) Not Available
☐ Other (Please specify): _____

☐ **SECTION B: PATIENT NOT PROCEEDING** *Complete only if patient is not proceeding for further follow up at your facility.*
Please ensure the patient's primary health care provider has been notified if the patient is not going to proceed.

☐ Patient had a total mastectomy, no further follow up required
☐ Patient declined follow up
☐ Patient was not able to be contacted
☐ Patient moved out of province
☐ Patient is medically unfit for follow up
☐ Patient went to a different facility for follow up. Facility Name (if known): _____
☐ Patient is deceased
☐ Other: _____

Completed By _____ Signature _____

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INFORMATION ON THIS FORM IS CONFIDENTIAL
IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604) 708-2114