INFORMATION REQUIRED BY CCMB REFERRAL OFFICE

BREAST

1. **GENERAL INFORMATION**

- Demographic information including phone number(s)
- Letter of referral
- History and physical
- Co-existing medical conditions
- Allergies
- Previous malignancy information (diagnosis and previous treatment)
- List of current medications (prescription, over the counter, vitamins, herbal supplements

2. **PATHOLOGY REPORTS**

A copy of the PATHOLOGY REPORT(S) from all diagnostic and surgical treatment procedures is required

- Fine needle aspiration [FNA] cytology *only if done*
- Core biopsy
- Definitive surgery – eg. Lumpectomy / Mastectomy
- Sentinel lymph node procedure and/or axillary lymph node dissection
- ER and PR and if invasive, Her2*

* *please check with pathology department to ensure ER, PR and Her2 have been ordered*

3. **OPERATIVE REPORTS**

- Diagnostic procedures
- Definitive surgery – Lumpectomy / Mastectomy
- Sentinel lymph node procedure and/or axillary lymph node dissection

4. **IMAGING REPORTS / STAGING INVESTIGATIONS**

- Mammogram
- Chest x-ray *only if done* for anesthetic (eg)
- Breast ultrasound *only if done* as part of diagnostic work up
- CT scan, Bone Scan and MUGA: *see stage by stage recommendations* below in “BASELINE STAGING TESTS”

BREAST ***continued***

BASELINE STAGING TESTS:

A. T1/T2 N0 [Node Negative] or DCIS

i. No CT Scan or Bone Scan is required
ii. If invasive tumor and triple negative (ie. ER-& PR- & Her2-) or Her2 positive: MUGA Scan is required. *If Her2 pending, may omit MUGA for T1/T2 N0.*
iii. Blood work – see #5 for standard blood work

B. pN1 [1-3 Nodes Positive] or T3 (>5cm.) N0

i. No CT Scan or Bone Scan is required
ii. MUGA Scan
iii. Blood work – see #5 for standard blood work

C. pN2 [4 or more nodes positive] or clinically palpable nodes *or*
D. Locally Advanced/Inflammatory [for Neoadjuvant treatment] *or*
E. Metastatic [original disease must have been biopsied or if new case presenting as stage IV there must be a biopsy]

i. CT Chest/Abdomen/Pelvis
ii. Bone Scan
iii. MUGA Scan
iv. Blood work – see #5 for standard blood work

5. BLOOD WORK

- CBC and differential
- Biochemistry: Na, K, Cl, Urea, Creatinine, Calcium
- Liver Function / Enzymes: Total Protein, Albumin, Alk Phos, ALT, AST, Total and Direct Bilirubin, GGT)
- Only for C, D, and E above: Tumor Markers CEA and CA 15-3

If the referring surgeon or physician has ordered tests, but they are not yet done, please provide dates (if available) and location where test is being done.

INSTRUCTIONS FOR PREPARING & SUBMITTING–

CancerCare Manitoba's *New Patient Referral Form*

You can fill in the CCMB ***New Patient Referral Form*** *(next page of this pdf file) using an Adobe Acrobat application (e.g. Reader, Pro) on your computer. If you are using Adobe Reader5.0 or higher to perform this task, please note that* ***Adobe has disabled the "save form" feature.*** *Therefore, after you fill in the form, be sure to print a copy(ies) before closing the window to avoid losing your data. Alternatively, you may print a blank form and fill it in by hand.*

As you do so, please follow these instructions:

1 Attach the "required referral information" specific to the DSG (or area of specialization) that is detailed in the preceding page(s) of this download package.

2 If the referring physician has ordered investigations that have not yet been completed or results are pending, please provide dates and location in the space provided on the referral form. For those referring offices that submit referral information from an electronic chart source, we request that the referral information be sent as separate documents, each labeled with the patient's name and health number. (i.e. x-ray report on one page, CBC on a separate page, operative report on another page, CT scan on its own page, etc.).

3 Have the Referring Physician **SIGN THE FORM**.

4 Please send above information together with the CCMB referral form by **FAX** to (204) 786–0621.

5 If the referring physician has or will be referring the patient to a community medical oncologist, please indicate this on the referral letter.

6 Please note if any investigations indicated were not completed or if the results are still pending. Lack of pertinent information **MAY DELAY** the scheduling of the patient's appointment. Additional investigations may be organized prior to the patient's first appointment.

7 If the referral is **emergent** (i.e.: your patient needs to be seen within 24 to 48 hours for immediate treatment with chemotherapy, radiation therapy or surgery for a life-threatening oncological emergency), please phone the Medical or Radiation Oncologist or surgical oncology service on-call through paging at Health Sciences Centre: (204) 787-2071 or at St. Boniface General Hospital: (204) 237-2053.

8 For **hematologic emergencies** please page the on-call hematologist at the above phone numbers.

9 **Is the patient aware of the diagnosis?** All patients should be made aware of their diagnosis by the Referring Physician prior to being referred to CancerCare Manitoba. CancerCare Manitoba staff will be contacting new patients by telephone to provide further information about their first appointment. If the patient is not aware of their diagnosis and referral to CancerCare Manitoba, they may experience undue stress and anxiety.

If you have a referral-related inquiry, please call (204) 787–2176.

Manitoba's Centre for Cancer Control & Blood Disorders

Referral by Fax: (204) 786 - 0621

Phone Inquiry: (204) 787 - 2176

NEW PATIENT REFERRAL FORM OPTIONS FOR ENTERING DATA ON THIS FORM:1. In Adobe Acrobat: Position your cursor in the first field below. Type the last name. Advance to the next field using the tab key. Tab & enter data to the bottom of the page. PLEASE NOTE that because Adobe has disabled the "save form" feature in Acrobat Reader 5.0 and later, you MAY NOT BE ABLE to save a copy of your form to your computer. Therefore to avoid data loss, print a copy(ies) of the form BEFORE YOU CLOSE THIS WINDOW. 2. By hand: Print off the form now and fill the information in by hand or typewriter. Include with your referral submission to CancerCare Manitoba.* The Referring Physician MUST sign this form.** This note disappears when the form is printed.

Patient Information (please print)

Surname: Given Name: Initial:

Maiden and Previous Name (s):

Date of Birth: _______/__________/________ day
month year

Sex: M F ☐☐

Address: City: Province: Postal Code:

Phone: Home: ( ) Work: ( )

Patient location: Home Hospital Specify unit:__________________ Unit phone #: _______________ ☐☐

Manitoba Health # :

PHIN# :

Does the patient have any special needs?
Wheelchair: Portable oxygen: Stretcher:
Other:______________ ☐☐☐

Does the patient speak English? Yes No If no, what language:_______________________ Need for an interpreter? Yes No ☐☐☐☐

Referral Information: to be completed and signed by the referring Physician.

Diagnosis:_________________________
Confirmed Presumptive ☐☐

Is the patient aware of diagnosis? Yes No If no, please explain:______________________ ☐☐

Reason for Consultation: Comments: Newly Diagnosed 2nd Opinion Recurrent / Progressive Disease ☐☐☐

Surgeon's Name (if different from referring physician):

Family Physician (if different from referring physician):

Referring Physician's Name:

Tel: ( ) Fax: ( )

Today's Date: ____/____/_____
day / month / year
ddmmyyyy

Signature of referring physician: **(Required)**

Required Information: Sent with Referral If result pending state date and place done:		
1) **Letter** (with History & physical; co-existing conditions; allergies; previous malignancy)		
2) **Pathology**		
3) **Operative reports**		
4) **Imaging**		
5) **Blood work**		
6) **Other**		

Patients will be notified of receipt of referral. Please complete & fax this form, referral letter together with required information. Lack of pertinent information MAY DELAY scheduling of patient's appointment.