Alberta Health Services

For Breast & Cervical Health Program
Label only

Breast & Cervical Health Program Referral

Lethbridge and Area

Fax completed form to 403.388.6647
If you have any question call 403.388.6324

Appointment Date and Time *(Program use only)*		
Date	**Time**	**Referred to**

Patient Information

Last Name	First Name	Date of birth *(dd/Mon/yyyy)*
PHN/ULI	Address	City
Province	Postal Code	Phone	Other Phone

Breast Health Reason for Referral *(Ensure patient has had a recent Mammogram or Ultrasound within the past 3 months)*

☐ Mammogram Findings
☐ High Risk Counselling
☐ Breast Pain
☐ Ultrasound Findings
☐ Breast Lump
☐ Other: _____
☐ Nipple Discharge
☐ 2nd Opinion

Cervical Health Reason for Referral *(Ensure last two PAP smear results attached)*

_____

_____

_____

Medications/Anticoagulants

☐ Patient is taking medication(s) *List* _____

_____

_____

☐ Patient is taking Anticoagulants

What Anticoagulants? _____

_____

Can Anticoagulants be stopped if a biopsy is required? *(Complete for Breast Health only)*

☐ Yes ➔ **Send physician orders dated within the last 24 hours**
☐ No

Referring Information

Clinic Name		**Physician**		
City	**Province**	**Postal Code**	**Fax**	**Office Phone**

For Office Use only

Date Received