



Breast – Surgical Oncology Referral Form

FOR URGENT REFERRALS CONTACT PHYSICIAN
DIRECTLY

1266 – 600 University Avenue
Toronto, Ontario, Canada M5G 1X5
C 300 Front (Rev. 10.2025) Page 1 of 1

Please indicate if you would like an appointment with the
next available surgeon or a specific surgeon:

- | | | | |
|--|--|--------------------------------------|--------------------------|
| <input type="checkbox"/> BREAST | <input type="checkbox"/> Dr. Andrea Covelli | Phone: 416-586-4800 ext. 5163 | Fax: 416-586-8847 |
| <input type="checkbox"/> Next available | <input type="checkbox"/> Dr. Alexandra Easson | Phone: 416-586-4800 ext. 2775 | Fax: 416-586-8847 |
| Fax: 416-586-8847 | <input type="checkbox"/> Dr. Wey Leong | Phone: 416-946-2992 | Fax: 416-946-4429 |
| | <input type="checkbox"/> Dr. Joanna Ryan | Phone: 416-586-4800 ext. 4793 | Fax: 416-586-8847 |
| <input type="checkbox"/> PLASTIC RECONSTRUCTION SURGERY | | Phone: 416-340-3143 | Fax: 416-340-4403 |
| Dr. Anne O'Neill | | | |

Is this referral a second opinion?

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

- | | |
|--|--|
| <input type="checkbox"/> Pathology reports | <input type="checkbox"/> Most recent clinic/consult note |
| <input type="checkbox"/> Tumour marker reports | <input type="checkbox"/> 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:			

