Dartmouth-Hitchcock
NORRIS COTTON CANCER CENTER

Phone: (603) 653-3500
Fax: (603) 653-3502
www.cancer.dartmouth.edu

Comprehensive Breast Program

Referral Form

Patient Name: Last _____ **First** _____ **MI** _____

DOB: _____ DHMC MR#: _____

Address: _____ City, ST: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Referring Provider: _____ Office #: _____

Contact Person: _____ Fax #: _____

Staff Physician (if different from above): _____ Office #: _____

Management of Care:

- ❑ Evaluate and treat at DHMC
- ❑ We/the patient would like a 2nd opinion only
- ❑ Please assume a subset of care:
  Specify: _____
- ❑ Familial Cancer Program (please call (800) 251-0097)

Additional Info:

Service/Appointment Requested (check all that apply):

- ❑ Mammogram/ultrasound & follow-up breast exam
- ❑ Second opinion on mammograms
- ❑ Biopsy (DHMC mammogram review required)
- ❑ Second opinion on films/scans
- ❑ Genetic testing/counseling/risk assessment
  (please call Familial Cancer Program (800) 251-0097)

Consultation with:

- ❑ Breast Surgeon
- ❑ Plastic Surgeon
- ❑ Medical Oncologist
- ❑ Radiation Oncologist

Presenting Symptom/Diagnosis: ❍ Left breast ❍ Right breast ❍ Both

- ❑ Abnormal mammogram
- ❑ Breast lump: Location: _____ cm from nipple _____
- ❑ Skin changes (describe): _____
- ❑ Nipple discharge (circle color): Black/Brown Red Tan Green Yellow Milky Clear
- ❑ New diagnosis of breast cancer: ❍ **L** ❍ **R** Type _____
- ❑ Prior diagnosis of breast cancer: ❍ **L** ❍ **R** Year of diagnosis _____ Type _____
- ❑ Family history of breast cancer: Relation to patient _____ Age at dx (if known) _____
- ❑ Family history of ovarian cancer: Relation to patient _____ Age at dx (if known) _____

Please mark location on diagram ▶

Previous Treatment:	**Dates (mm/yy) and Location(s) of Treatment:**
❑ Mammogram/Ultrasound (Important: list all facilities where **last three** mammograms have been done, and specify approximate dates)	
❑ Biopsy – Diagnosis? _____	
❑ Surgery - Type? _____	
❑ Chemotherapy _____	
❑ Radiation therapy _____	
❑ Other: _____	

Information required:	**Send to:**
◆ All office and treatment notes, mammo and ultrasound reports, pathology reports, labs – current/prior diagnosis	Fax #: (603) 653-3502
◆ Films: mammograms (last 3 available), MRI's, ultrasounds, scans	Attn: Mammo Review, DHMC, One Medical Center Drive, Lebanon, NH 03756
◆ Pathology slides for general surgery or medical oncology referrals	Attn: Wendy Wells, Pathology, DHMC, One Medical Center Drive, Lebanon, NH 03756

Rev. 4-28-11