

Breast Diagnostic Assessment Program (DAP) Referral Form

Royal Victoria Regional Health Centre
201 Georgian Drive, Barrie, ON L4M 6M2
Phone: 705-728-9090 ext. 43144

PATIENT INFORMATION:			
Surname:	First Name:	Gender <input type="checkbox"/> F <input type="checkbox"/> M	D.O.B (dd/mm/yyyy)
Address:	City/Province:	Postal Code:	Phone #:
Patient's Email:	Patient's Pharmacy:	OHIP # (with version code):	RVH V# (if applicable):
REFERRING PHYSICIAN INFORMATION:			
Referring Physician Name:	Referring Physician Phone #:	Billing #:	
Relevant History/Complete Patient Profile Information (or attach copy of CPP):			
<input type="checkbox"/> I confirm that patient is aware of diagnosis of breast cancer			
Primary Care Provider's Signature:			
<input type="checkbox"/> Next available surgeon or <input type="checkbox"/> Dr. _____			
Barrie:	Drs. Allard-Ihala, Barnett, Hanrahan, Mutabdzic, Sklar		
Collingwood:	Drs. Akinyele, Lisi		
Midland:	Dr. Sacks		
Orillia:	Drs. Bauman, Chaudhuri		
Bracebridge:	Drs. Gupta, Reid		
Huntsville:	Drs. MacMillan, Roldan, Wasilewski		
<i>*Doctors located outside of RVH, please fax your appointment date and time to (705)739-5636 for our records.</i>			
Appointment Date: _____ Appointment Time: _____			

Please fax completed form to 705-739-5636.

To ensure timely access to care, we will follow-up 48 business hours after initial referral is sent to primary care provider.

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