PHYSICIAN REFERRAL FORM
BREAST SPECIALTY OF BATON ROUGE
MICHAEL W. HAILEY, MD

To refer a patient to Dr. Hailey, please complete this form and fax it along with patient specific reports/info to (225) 753-2778 (BRST). Please phone us with questions at (225) 751-2778 (BRST).

Patient Information

Name:		
Date of birth:	SSN:	Phone Day:
Referring MD Name: Please Provide a Fax number where we can send a follow up : ( )	Referral: O URGENT O Routine	Alternate Phone:

Reason for Referral (please check all that apply)

- O Abnormal mammogram and/or ultrasound. Evaluate and treat.
- O Breast lump/mass on the: Right Left
- O Nipple Discharge
- O Breast Pain/Tenderness
- O Fibrocystic changes
- O Worrisome Family History of Breast/Ovarian Cancer
- O New Diagnosis of Breast Cancer
- O Breast Abscess/Infection
- O Gynecomastia
- O Patient needs placement of venous access Device (Port) for chemotherapy
- O Other: _____

Please answer the following:

Has this patient had any breast imaging studies? YES NO If yes, where were they performed?

Has this patient had any surgical procedures for which pathology reports are available? YES NO

Where can we find them? Please fax or list facility name: _____

Please provide any additional information in this area that will assist us in taking care of your patient.

Confidentiality Notice

For office use only:

O Patient contacted by _____

O Appointment made on _____ at _____ AM/PM