REFERRAL FORM
RADIOLOGY ONLY

sydney breast clinic
peace of mind

PLEASE FAX OR EMAIL REFERRAL PRIOR TO APPOINTMENT

SYDNEY BREAST CLINIC

LEVEL 12, 97-99 BATHURST ST, SYDNEY NSW 2000
FAX: 02 8251 4070 • EMAIL: INFO@SYDNEYBREASTCLINIC.COM.AU

TELEPHONE **02 8251 4000** FOR AN APPOINTMENT

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

TELEPHONE NUMBER: _____

EMAIL: _____

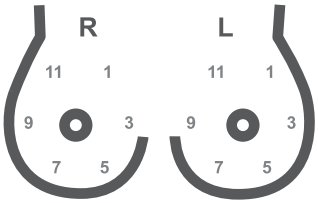
ADDRESS: _____

_____

REQUEST FOR:

- ☐ +/-MAMMOGRAPHY/TOMOGRAPHY
- ☐ +/- CONTRAST ENHANCED MAMMOGRAPHY
- ☐ +/- ULTRASOUND
- ☐ +/- BIOPSY (CYTOLOGY/CORE)
- ☐ +/- SOZO® SURVELLIANCE
- ☐ +/- BREASTEST plus™

CLINICAL NOTES: *A REQUIREMENT FOR A MEDICARE REBATE*



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REFERRING DOCTOR DETAILS

NAME: _____

ADDRESS: _____

PROVIDER #: _____ PHONE: _____

EMAIL: _____ FAX: _____

SIGNATURE: _____