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: _____

_____

CLINICAL NOTES:
A REQUIREMENT FOR A MEDICARE REBATE

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_____

REQUEST FOR:

- ☐ +/-MAMMOGRAPHY/TOMOGRAPHY
- ☐ +/- CONTRAST ENHANCED MAMMOGRAPHY
- ☐ +/- ULTRASOUND
- ☐ +/- BIOPSY (CYTOLOGY/CORE)
- ☐ +/- BIOPSY MARKER INSERTION
- ☐ +/- SOZO® SURVELLIANCE
- ☐ +/- BREASTEST plus™
- ☐ +/- SAVI SCOUT INSERTION (ULTRASOUND GUIDED)
- ☐ +/- SAVI SCOUT INSERTION (MAMMOGRAM GUIDED)
- ☐ +/- POST SAVI SCOUT MAMMOGRAM

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_____

REFERRING DOCTOR DETAILS

NAME: _____

ADDRESS: _____

PROVIDER #: _____ PHONE: _____

EMAIL: _____ FAX: _____

SIGNATURE: _____