



sydney **breast** clinic  
peace of mind

# REFERRAL FORM

## MULTIDISCIPLINARY

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](mailto:INFO@SYDNEYBREASTCLINIC.COM.AU)

TELEPHONE **02 8251 4000** FOR AN APPOINTMENT

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

MOBILE NUMBER: \_\_\_\_\_

EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

### REQUEST FOR BREAST ASSESSMENT

- ☒ +/- CLINICAL BREAST EXAMINATION
- ☒ +/- MAMMOGRAPHY / TOMOGRAPHY
- ☒ +/- CONTRAST ENHANCED MAMMOGRAPHY
- ☒ +/- ULTRASOUND
- ☒ +/- FNA / CORE BIOPSIES
- ☒ +/- BREASTEST *plus*™
- ☒ +/- GENETIC TESTING

☐ **REQUEST FOR BONE MINERAL DENSITY TESTING (BMD) AVAILABLE AT ANY AGE WITH RISK FACTORS OF OSTEOPOROSIS IF PATIENT IS ELIGIBLE FOR A MEDICARE REBATE, PLEASE SPECIFY ITEMS NUMBER:**

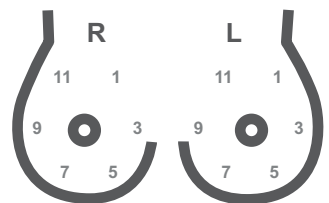
- |                                  |                                  |                                  |
|----------------------------------|----------------------------------|----------------------------------|
| <input type="radio"/> ITEM 12306 | <input type="radio"/> ITEM 12315 | <input type="radio"/> ITEM 12321 |
| <input type="radio"/> ITEM 12312 | <input type="radio"/> ITEM 12320 | <input type="radio"/> ITEM 12322 |

### TO MEET MEDICARE REIMBURSEMENT REQUIREMENTS, PLEASE TICK ONE OR MORE:

- |                                                                                  |                                                        |                                                                                  |
|----------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> PREVIOUS BREAST CANCER                                  | <input type="checkbox"/> LUMP / LUMPINESS / THICKENING | <input type="checkbox"/> PAIN / DISCOMFORT                                       |
| <input type="checkbox"/> RISK OF BREAST CANCER DUE TO SIGNIFICANT FAMILY HISTORY | <input type="checkbox"/> SKIN DIMPLING                 | <input type="checkbox"/> NIPPLE SYMPTOM: RETRACTION/ DISCHARGE/SKIN CHANGE/OTHER |
| <input type="checkbox"/> SHORT-TERM FOLLOW UP OF _____                           | <input type="checkbox"/> SECOND OPINION OF _____       | <input type="checkbox"/> OTHER SYMPTOM/S OR SIGN/S _____                         |

### OR COMPLETE CLINICAL NOTES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



### REFERRING DOCTOR DETAILS:

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PROVIDER NUMBER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ FAX: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_

# ON THE DAY OF YOUR APPOINTMENT PLEASE:



- REFRAIN FROM USING DEODORANT PRIOR TO YOUR VISIT. YOU MAY BRING IT ALONG WITH YOU TO USE AFTER YOUR VISIT.
- FOR YOUR COMFORT, WEAR A TWO-PIECE OUTFIT, SUCH AS A SKIRT OR TROUSERS WITH A TOP.
- NOTE YOUR VISIT MAY TAKE 4 HOURS OR LONGER DEPENDING ON INDIVIDUAL NEEDS.
- FEES ARE PAYABLE ON THE DAY - ACCEPTED METHODS: CASH, MASTERCARD, VISA, AMEX OR EFTPOS.

## PATIENT INFORMATION

AN APPOINTMENT IS ESSENTIAL FOR ALL SERVICES AT THE CLINIC.

A REFERRAL WITH CLINICAL INFORMATION IS ESSENTIAL FOR A MEDICARE REBATE.

TO MAKE AN APPOINTMENT PLEASE PHONE: **02 8251 4000**

### YOUR APPOINTMENT DETAILS:

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

*IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT  
PLEASE PROVIDE 24 HOURS NOTICE.  
(CANCELLATION FEE MAY APPLY)*



## WHERE TO FIND US:

LEVEL 12, 97-99 BATHURST STREET,  
SYDNEY NSW 2000

**T** 02 8251 4000

**F** 02 8251 4070

**W** [SYDNEYBREASTCLINIC.COM.AU](http://SYDNEYBREASTCLINIC.COM.AU)

**E** [INFO@SYDNEYBREASTCLINIC.COM.AU](mailto:INFO@SYDNEYBREASTCLINIC.COM.AU)

PARKING AVAILABLE AT THE CINEMA CARPARK WITH  
ENTRY FROM KENT OR SUSSEX STREETS

**APPOINTMENTS 02 8251 4000**