sydney breast clinic
peace of mind

SYDNEY BREAST CLINIC REFERRAL / IMAGING REQUEST

Level 12, 97-99 Bathurst St Sydney NSW 2000
Phone: 1300 65 30 65 | Fax: 02 9283 1158

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Request for Breast Assessment

- [x] +/- Clinical Breast Examination
- [x] +/- Mammography/ Tomography
- [x] +/- Ultrasound
- [x] +/- FNA/ Core Biopsies

Clinical reasons* for referral, please tick (one or more):
** Clinical notes are mandatory for Medicare rebate*

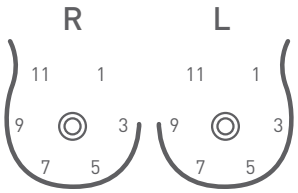
- [ ] lump / lumpiness / thickening
- [ ] skin dimpling
- [ ] pain / discomfort
- [ ] nipple symptom: retraction/discharge/skin change/other
- [ ] short- term follow up of _____
- [ ] second opinion of _____
- [ ] HRT usage
- [ ] previous breast cancer
- [ ] family history of breast or ovarian cancer
- [ ] other symptom/s or sign/s _____

- [ ] **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 item number:

- [ ] Item 12306
- [ ] Item 12321
- [ ] Item 12312
- [ ] Item 12323
- [ ] Item 12315

** Clinical notes are mandatory for Medicare rebate*



Clinical Notes* _____

_____

_____

_____

Referring Doctor Details:

Name: _____

Address: _____

Provider No. _____ Phone: _____

Signature: _____ Fax: _____

Email: _____

** Clinical notes for Medicare rebate*