HIGH RISK BREAST CLINIC
PATIENT REFERRAL FORM

Perth Breast Cancer Institute
High Risk Breast Clinic
Suite 404, Level 4,
Hollywood Consulting Centre,
91 Monash Ave, Nedlands, WA 6009

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Healthlink breastci

breast cancer research centre-wa

PATIENT DETAILS

Title: | First Name: | Last Name: | DOB:

Address:

Mobile Phone: | Email:

ATSI Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

CLINICAL HISTORY

Does the patient have a history of any of the following: ***(Please attach any relevant imagine, reports or results.)***

eg. PRC, SKG

☐	Mammogram	Date:	Provider:
☐	Ultrasound	Date:	Provider:
☐	MRI	Date:	Provider:
☐	Biopsy/FNA	Date:	Provider:
☐	Genetics	Date:	Provider:

Other details:

PERSONAL HISTORY

Has anyone in the family had genetic testing or attended a genetic clinic? ☐ Yes ☐ No Details:

(Please attach any relevant imaging, reports or results.)

Does the patient have Jewish ancestry? ☐ Yes ☐ No Details:

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PERSONAL HISTORY *continued*

Does the patient have a history of any of the following: ***(Please attach any relevant documentation)***

☐	Breast Cancer	Details:
☐	Ovarian Cancer	Details:
☐	Prostate Cancer	Details:
☐	Pancreatic Cancer	Details:
☐	Other Cancer	Details:

REFERRER'S DETAILS ***Only if GP or Specialist is referring***

Name:

Provider Number:

Practice Name:

Preferred Contact Number:

Healthlink ID:

Email:

Fax:

Are you the patient's usual GP? ☐ Yes ☐ No

Notes:

Learn more about the PBCI High Risk Breast Clinic:

www.bcrc-wa.com.au