BREAST CLINIC
PATIENT REFERRAL FORM

breast cancer research centre-wa

Perth Breast Cancer Institute
High Risk Breast Clinic
Suite 404, Level 4,
Hollywood Consulting Centre,
91 Monash Ave, Nedlands, WA 6009
T 6500 5576
F 6500 5574
E pbcibreastclinic@bcrc-wa.com.au
Healthlink breastci

Dr Susie Kitchin
Provider No: 227257HX

Dr Pamela Thompson
Provider No: 217794NH

☐ Urgent Review Next Available ☐ Routine Review

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 imaging, reports or results.)***

eg. PRC, SKG

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

Other 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