

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
T 6500 5576
F 6500 5574
E pbcbreastclinic@bcrc-wa.com.au
Healthlink breastci

Dr Susie Kitchin
Provider No: 227257HX

Dr Pamela Thompson
Provider No: 217794NH



breast cancer
research centre-wa

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

<input type="checkbox"/> Mammogram	Date: <input type="text"/>	Provider: <input type="text"/>
<input type="checkbox"/> Ultrasound	Date: <input type="text"/>	Provider: <input type="text"/>
<input type="checkbox"/> MRI	Date: <input type="text"/>	Provider: <input type="text"/>
<input type="checkbox"/> Biopsy/FNA	Date: <input type="text"/>	Provider: <input type="text"/>
<input type="checkbox"/> Genetics	Date: <input type="text"/>	Provider: <input type="text"/>

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