Beacon Hospital

DIAGNOSTIC BREAST SERVICE
Direct Fax Line: 01 293 8641
Beacon Hospital Outpatients Department

Name of Referring Doctor: _____

Address: _____

_____

Patient Name: _____

Patient Address: _____

_____

Date of Birth: _____/_____/_____

Telephone: _____ **Mobile:** _____

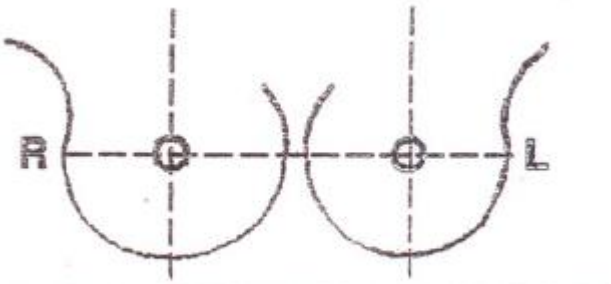
Tentative Diagnosis: _____

Physical Findings:

Breast: _____

Axilla: _____

Neck: _____



Has Patient had a Mammogram: Yes ☐ No ☐

If Yes – Where: _____
When: _____
Outcome: _____

Is there a Family History of Breast Cancer: _____

GP's Signature: _____ Date: _____

Please inform your patient if they have not received an appointment within 72 hours to contact Beacon Hospital Outpatients Department on 01 293 8686