Beacon Hospital

DIAGNOSTIC BREAST SERVICE REFERRAL FORM - BEACON HOSPITAL OUTPATIENTS DEPARTMENT

DIRECT FAX LINE: 01 293 8641

GP DETAILS

Name of Referring Doctor

Surgery Address

PATIENT DETAILS

Patient Name

D.O.B.

Address

Landline

Mobile

CLINICAL DETAILS

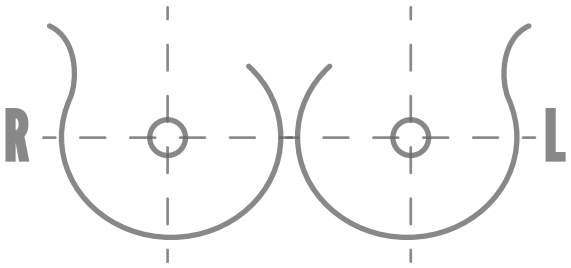
Tentative Diagnosis

Physical Findings

Breast

Axilla

Neck



MAMMOGRAM HISTORY

Has Patient had a Mammogram? ☐ Yes ☐ No

If 'Yes' Where:

When:

Outcome:

Is there a Family History of Breast Cancer? ☐ Yes ☐ No

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