

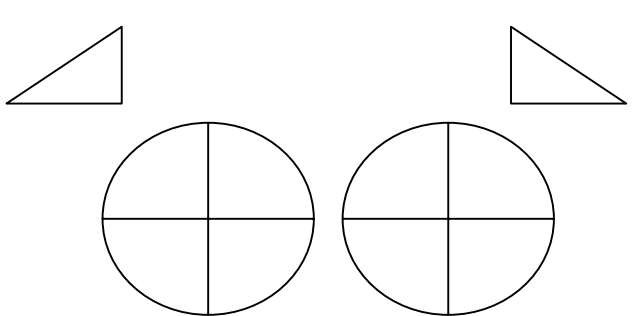
BATH BREAST IMAGING SERVICES

PRIVATE PATIENT REFERRAL FORM

RUH REG NO:	NHS NO:	GP NAME:
SURNAME:	FORENAME:	SURGERY:
MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	D.O.B:	
ADDRESS:		
POSTCODE:		TELEPHONE:
TEL. HOME:		FAX:
WORK:		

REFERRAL DATE:	PMH BREAST DISEASE: YES NO
	DETAILS:

<p>PLEASE INDICATE BY TICKING ONE BOX BELOW</p> <p><input type="checkbox"/> <u>URGENT REFERRAL</u> SUSPECTED BREAST CANCER:</p> <p><input type="checkbox"/> <u>NON-URGENT REFERRAL</u> <input type="checkbox"/> ROUTINE within 2 WEEKS <input type="checkbox"/> FAMILY HISTORY</p> <p>ALL SYMPTOMATIC PATIENTS SEEN WITHIN 2 WEEKS <i>Please indicate clinical suspicion to help assign most appropriate appointment.</i> <i>Thank you</i></p>	<p><i>Urgent referral advised</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Discrete breast lump<input type="checkbox"/> Skin tether/contour change<input type="checkbox"/> Nipple inversion/retraction/ulceration<input type="checkbox"/> Blood stained nipple discharge <p><i>Non-urgent referral advised</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Asymmetrical nodularity<input type="checkbox"/> Breast pain<input type="checkbox"/> Persistent nipple discharge<input type="checkbox"/> Abscess/Mastitis<input type="checkbox"/> Recurrent cyst
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<u>CLINICAL EXAMINATION:</u>	<u>COMMENTS:</u>
	
<u>DATE OF LAST MAMMOGRAM</u>	

<u>FAX: 01225 824912</u>	BATH BREAST IMAGING SERVICES
<u>Email:</u> bathbreastimaging@gmail.com	c/o Dr Goddard's secretary Bath Breast Unit 01225 821862

<u>UNIT USE ONLY:</u>	
CONSULTANT TRIAGE:	
DATE RECEIVED:	DATE OF APPOINTMENT: