

SPECIALIST REFERRAL For Breast Assessment and Imaging/Investigations

Date of surgeon review appointment: ____ / ____ / ____

The diagnostic imaging services (DIS) requested in this form can be taken to a diagnostic imaging provider of the patient's choice.

Patient Details

Name: _____ DOB: _____ Medicare number: _____

Address: _____

Email: _____ Contact number: _____

Referral for breast imaging (✓select to indicate)

- | | | | | |
|---|--------------------------------|-------------------------------|------------------------------------|--|
| <input type="checkbox"/> Mammography/
Tomography | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Bilateral | } <input type="checkbox"/> Core biopsy |
| <input type="checkbox"/> Contrast enhanced
mammography (CEM) | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Bilateral | |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Right | <input type="checkbox"/> Left | <input type="checkbox"/> Bilateral | |
| <input type="checkbox"/> Breast cancer risk assessment | | | | |

IV Contrast ALERT

Referrer to complete for contrast enhanced mammography

Diabetes metformin treatment?

Yes No

Contrast allergy?

Yes No

Renal impairment?

Yes No

Creatinine level:

eGFR: _____

Date: ____ / ____ / ____

Pregnant?

Yes No

Procedure (✓select to indicate)

- Right Left
- Fine needle biopsy
- Core biopsy
- Contrast enhanced mammography
- Vacuum assisted biopsy (Stereotactic/Tomo)
- MRI biopsy
- Marker clip

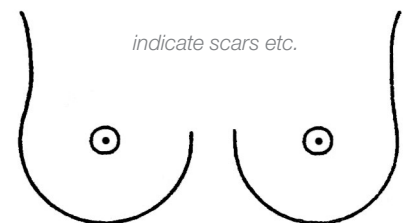
Please select ✓ one or more:

Previous breast cancer Right Left

Type: IDC DCIS ILC Other: _____

Date: ____ / ____ / ____ Size: _____

- | | |
|---|---|
| <input type="checkbox"/> Neoadjuvant chemotherapy | <input type="checkbox"/> Breast implants |
| <input type="checkbox"/> Conservative surgery | <input type="checkbox"/> Breast reduction surgery |
| <input type="checkbox"/> Hormonal therapy | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Reconstructive surgery | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Previous benign breast surgery | <input type="checkbox"/> Radiotherapy |
| <input type="checkbox"/> Other symptom(s) or sign(s): _____ | <input type="checkbox"/> Marker clips |



Pre-Operative localisation and specimen imaging

(✓select to indicate)

Right Left

- Savi scout
- Hookwire
- Stx or tomo
- US & site:

Other: _____

Specimen imaging

Date of surgery: ____ / ____ / ____

Clinical notes & current concerns:

Clinical notes are required for Medicare rebate to be applied (where relevant)

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Allergies

Current medications

Previous imaging:

Referring Doctor Details

Name:

Date of referral:

/ /

Address:

Phone:

Fax:

Email:

Signature:

Your Next Appointment

At

am/pm on

Should your symptoms alter significantly or you are worried about the timing of your appointment please consult your referring Doctor who will contact the Wesley Breast Clinic (the Clinic) if a more urgent appointment is required.

Information for your visit to the Clinic ...

General Information

- + Please ring us if you have any enquiries; if you wish to change your appointment; or if you are unable to attend.
- + Please inform us prior to your appointment if you have had previous breast imaging elsewhere.
- + Please do not wear cream or talcum powder on your breast area. You may wear non-aerosol deodorant.
- + Please avoid wearing perfume.
- + It is a good idea to wear separates.
- + Your visit will probably involve some waiting so you may like to bring something to help occupy your time.
- + As we are a comprehensive Breast Imaging clinic you may be here for up to 4 hours.

To Make an Appointment at the Clinic

Telephone: 07 3232 7202 between 8.30am and 5.00pm Monday to Friday

Fax: 07 3217 8840

Email: wesleybreastclinic@uhealth.com.au



wesley.com.au

Clinic Details

Location: Level 1, The Sandford Jackson Building
The Wesley Hospital
Cnr Coronation Drive & Chasely Street,
Auchenflower Qld 4066
(Adjacent to Auchenflower railway station, parking also available at The Wesley)

Postal Address: PO Box 499, Toowong Qld 4066

Email: wesleybreastclinic@uhealth.com.au



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