HERMITAGE
MEDICAL CLINIC

Referral Form

Please forward referrals to:
Hermitage Medical Breast Clinic, Old Lucan Rd, Dublin 20
Email: radiology@hermitageclinic.ie **Tel:** 01 6459 042 **Fax:** 01 6459 128

PATIENT DETAILS

Name of patient:_____ Date of birth:_____

Address:_____

Phone:_____ Mobile:_____

Email:_____

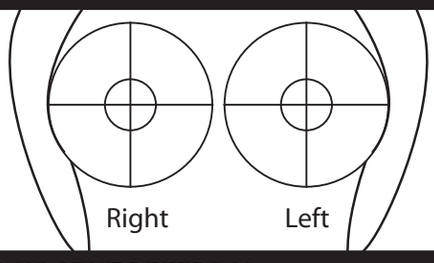
PRESENTING COMPLAINT

PHYSICAL EXAMINATION

Breast

Axilla

Other



URGENT REFERRAL:		NON-URGENT REFERRAL:	
PLEASE TICK RELEVANT BOX / BOXES	✓	***PLEASE TICK RELEVANT BOX / BOXES***	✓
Discrete breast or axillary lump		Asymmetrical nodularity	
Ulceration / erythema / oedema		Clinically benign breast lump	
Skin nodule		Refilling / recurrent cyst	
Nipple eczema		Pain not responding to simple measures	
Recent nipple retraction/distortion		Nipple discharge (not blood-stained)	
Nipple discharge (blood stained)		Other	
Abscess			
High suspicion of breast cancer on physical examination			

Personal history of breast cancer Yes ○ No ○ Specify: Side_____Year _____

Family history of breast cancer Yes ○ No ○ Specify: _____

Has the patient had a previous mammogram? Yes ○ No ○ If yes, Where _____Year _____

REFERRING DOCTOR

Name of GP:_____ Address:_____

Phone: _____ Email:_____ Fax:_____

GP Signature:_____

For office use only:_____

Date referral received: / / Appointment date: / /