



**BON SECOURS HOSPITAL**  
College Road, Cork.

# SPECIALIST BREAST CARE CENTRE

Mr. D. Gough, Ms. D. O'Hanlon,  
Mr. M. O'Sullivan, Mr. B. Whooley

**Patient Details**

Name : \_\_\_\_\_

Address: \_\_\_\_\_

Gender:  Female  Male

DOB : \_\_\_\_\_ Ph : \_\_\_\_\_

Mobile : \_\_\_\_\_

Insurance Details : \_\_\_\_\_

**Referring Doctor**

Name : \_\_\_\_\_

Practice Address : \_\_\_\_\_

Ph : \_\_\_\_\_ Fax : \_\_\_\_\_

G.P. Name (if different from Referring Dr.) \_\_\_\_\_

Date of Referral : \_\_\_\_\_

Previous attendance at Bon Secours  
Specialist Breast Care Centre:  Yes  No

Consultant : \_\_\_\_\_

Previous Breast Disease :  Yes  No

Details : \_\_\_\_\_

Previous Mammogram :  Yes  No

Details : \_\_\_\_\_

**Urgent Referral**

Please Tick As Appropriate

Suspicious Breast Lump

Skin Tethering / contour change

Nipple Inversion/Ulceration/Retraction

Blood Stained Nipple Discharge

Other

Details : \_\_\_\_\_

**Non - Urgent Referral**

Please Tick As Appropriate

Clinically benign breast lump

Recurrent cyst

Nodularity / Breast Pain

Abscess / Mastitis

Positive Family History

Other

Details : \_\_\_\_\_

**Clinical Findings - Breast Examination**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature Of Referring Doctor: \_\_\_\_\_

**For Office Use Only**

Date Referral Received: \_\_\_\_\_

Date of Appt: \_\_\_\_\_

Seen Within Guidelines:  Yes  No

Reason (If No): \_\_\_\_\_

Consultant Priority :

Urgent

Non-Urgent

**Tel: 021 4941910 / 021 4941913**  
Please Fax Referral To: 021 4941911 or post to  
**Specialist Breast Care Centre, Bon Secours Hospital, College Rd., Cork**