



Queensland Government  
Queensland Health

WIDE BAY HEALTH SERVICE

**MCGRATH BREAST CARE NURSE  
REFERRAL FORM**

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex:  M  F

**Please complete all relevant sections and sign.**

**Fax referrals to: 4150 2819 or Telephone: 4150 2812 Mobile: 0400713508**

Date of Referral \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Surgery (if known) \_\_\_\_/\_\_\_\_/\_\_\_\_

Referral Origin:  Public Hospital  Private Hospital

Name of Hospital..... Name of Unit.....

BreastScreen  Self / Family / Carer

Diagnosis Confirmation: When diagnosis confirmed ...../...../.....  
Where diagnosis confirmed .....

Consultant..... Current GP.....

Patient aware of diagnosis?  YES  NO If No, details.....

Patient aware of referral?  YES  NO If No, details.....

Patient Contact Details: Home Phone Number..... Mobile.....

Are contact details different during treatment?  YES  NO If Yes, Phone Number.....

Address.....

Interpreter Required?  YES  NO If Yes, language.....

Special Cultural Needs?  YES  NO If Yes, details.....

Does the patient live alone?  YES  NO If No, details.....

Name of Person ..... Relationship.....

Comments.....

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**REFERRING PERSON:**

Signature Designation Date

Print Name Contact Number

DO NOT WRITE IN THIS BINDING MARGIN

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