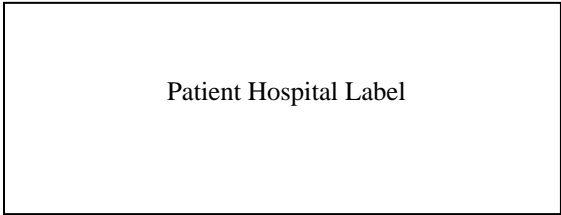


BREAST SURGERY GALLERY REFERRAL FORM

NAME _____

ADDRESS _____



WA POST CODE _____

HOME PHONE NO. (08) _____

NOK _____

MOBILE _____

WORK PHONE NO. _____

AGE _____

DOB _____

ETNICITY ASIAN CAUCASIAN INDIGENOUS OTHER _____

INTERPRETER REQUIRED Y N LANGUAGE _____

DIAGNOSIS R L B/L _____

BRA SIZE 8 10 12 14 16 18 20 22 24 26 CUP SIZE A B C D DD E F G H

PERSON REFERRING _____

PHONE (08) _____ FAX (08) _____

GP _____

PHONE (08) _____ FAX (08) _____

What surgical options have been recommended for you?

LUMPECTOMY MASTECTOMY IMMEDIATE RECONSTRUCTION DELAYED RECONSTRUCTION

TRAM FLAP LATISSIMUS DORSI FLAP IMPLANTS NIPPLE RECONSTRUCTION REDUCTION

BREAST SURGEON _____

PHONE (08) _____ FAX (08) _____

PLASTIC SURGEON _____ APPT. ____/____/____

PHONE (08) _____ FAX (08) _____

DIABETIC Y N PREVIOUS ABDO SURGERY Y N SMOKER Y N

SIGNITURE of PARTICIPANT _____ DATE _____

BREAST SURGERY GALLERY PH ; (08) 9224 3321 FAX (08) 9224 1684
ADDRESS; Breast Surgery Gallery Consultants, Breast Clinic, Level 3 North Block, Box X2213 GPO Perth WA 6847

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ACTIVATED ____/____/____

CONTACTED ____/____/____

APPT ____/____/____