GP Referral To The Breast Clinic @ APSA

Ph: (08) 8213 1800 Fax: (08) 8213 1811
Email: padrfosh@apsa.com.au

Dr Beverley Fosh

Patient details:

Surname: _____ **Name:** _____

DOB: ___ / ___ / ___

Private Health Fund: _____ **Membership No:** _____

Patient Address: _____

Telephone **H:** _____ **W:** _____ **M:** _____

Priority: **Urgent** **Within 1 Week** **Non Urgent**
(please circle)

GP Details:

Name: _____

Address: _____

Telephone: _____ **Fax:** _____

Provider No: _____ **Date:** ___ / ___ / ___

Duration of Referral: **3 months** **12 months** **Indefinite**
(please circle)

Reason for Referral:

Past Medical History:

Allergies: _____

Medications: _____

Imaging: **Completed with results attached / Not completed**

Pathology: **Completed with results attached / Not completed**

Breast Screen Letter Attached: **Yes / No**

Please circle preferred consultation site:

Western Community Hospital / **Bensons Radiology North Adelaide**

Signature: