|  |  |
| --- | --- |
|  | **Breast Pain Referral Form**  ***Please refer via the e-Referral Service*** |

|  |  |  |
| --- | --- | --- |
| **Referring GP** | <Sender Name> | |
| **Date of GP decision to refer** | <Today's date> | |
|  | |  |

**Patient Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name** | <Patient Name> | | |
| **Address** | <Patient Address> | | |
| **DOB** | <Date of Birth> | **NHS No.** | <NHS number> |
| **Home Tel. No.** | <Patient Contact Details> | **Gender** | <Gender> |
| **Mobile Tel. No.** | <Patient Contact Details> | **Ethnicity** | <Ethnicity> |
| **Preferred Tel. No.** | <Patient Contact Details> | **Email Address** | <Patient Contact Details> |
| **Main Spoken Language** | <Main spoken language> | **Interpreter needed?** | <Diagnoses>  Yes  No |
| **Transport needed?** | Yes  No | | |
| **Communication requirements:** | Hard of hearing:  Visually Impaired:  Learning/Mental Difficulties:  Hearing: <Diagnoses>  Vision: <Diagnoses>  Learning Disability: <Diagnoses> | | |

**Registered GP Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Practice Name** | <GP Details> | | |
| **Registered GP** | <GP Name> | **Usual GP** |  |
| **Registered GP Address** | <GP Details> | | |
| **Tel No.** | <GP Details> | **Fax No.** |  |
| **GP Bypass Number** |  |  | |
| **Email** | <Organisation Details> | **Practice Code** | <GP Details> |

**PLEASE CONFIRM YOU HAVE MANAGED THE PATIENT IN PRIMARY CARE FOR 3 MONTHS USING** [**THE EMBEDDED MASTALGIA PATHWAY**](https://clinical-pathways.org.uk/clinical-pathways/breast-pain-management) **BEFORE REFERRING TO THE BREAST PAIN CLINIC BY TICKING THIS BOX**

|  |  |
| --- | --- |
| **Please tick to confirm you have advised the patient that this clinic appointment will not involve any diagnostic tests.** |  |
| **Number of times you have seen the patient for Breast Pain** |  |
| **Length of time you have seen the patient for Breast Pain (months)** |  |
| **Exclusion criteria:**   1. **Abnormal examination** 2. **Previous history of breast cancer** 3. **Breast implants** 4. **Male Patients** 5. **Women under 16 years** | |

|  |
| --- |
| **Presenting symptoms**    <Event Details> |

|  |
| --- |
| **Examination** |

|  |
| --- |
| **Date of last mammogram** |

|  |
| --- |
| **Cancer Family History** |

|  |  |
| --- | --- |
| **Significant medical history** Yes  No  **If Yes please state**   |  | | --- | | **Problem** |     <Problems>  <Summary> |

|  |
| --- |
| **Medications** Yes  No  **If Yes please state**  Acutes: <Medication>  Repeats: <Repeat templates> |

|  |
| --- |
| **Allergies**  <Allergies & Sensitivities> |