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|  | **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**
 |

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| --- |
| **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> |