Symptomatic Breast Disease.
Direct Access Symptomatic and Routine Patients.
All care co-ordinated under one roof by multi-disciplinary team.

Triple Assessment Clinics
- Consultant Surgeons and Radiologists affiliated with National Breast Screening Programme
- Consultant Delivered and Led Care
- Dedicated Breast Care Nurses

Daily Imaging Clinics
- Digital Mammography
- High Resolution Ultrasound
- Interventional Breast techniques
- Breast MRI

REFERRAL CRITERIA

<table>
<thead>
<tr>
<th>Urgent Referrals</th>
<th>Non-Urgent Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High suspicion of breast cancer at any age</td>
<td>• Clinically benign breast lump</td>
</tr>
<tr>
<td>• Discrete breast or axillary lump</td>
<td>• Asymmetrical nodularity</td>
</tr>
<tr>
<td>• Ulceration/erythema/oedema</td>
<td>• Pain not responding to simple measures</td>
</tr>
<tr>
<td>• Skin nodule</td>
<td>• Nipple discharge that is not blood stained</td>
</tr>
<tr>
<td>• Nipple eczema</td>
<td></td>
</tr>
<tr>
<td>• Recent nipple retraction/distortion</td>
<td></td>
</tr>
<tr>
<td>• Blood stained nipple discharge</td>
<td></td>
</tr>
<tr>
<td>• Suspected breast abscess</td>
<td></td>
</tr>
</tbody>
</table>

REFERRAL PROCESS

GP Referral required
- Referrals using form on the reverse or by letter via fax, email, post or HealthLink
- Referrals triaged and patients offered appointments in line with recommended guidelines
- Patients with high suspicion of breast cancer should be referred for Triple Assessment
Specialist Breast Centre - Referral Form

Specialist Breast Centre, Mater Private Hospital, Eccles St., Dublin 7
T: 01 - 885 8294 | F: 01 - 885 8295 | E: breastcentre@materprivate.ie

Consultant Surgeon: First available □ or specify surgeon _______________________

GENERAL PRACTITIONER DETAILS

Name: ____________________________________________________________
Address: _________________________________________________________
_________________________________________________________________
_________________________________________________________________
Tel: __________________________ Fax: ________________________________

Referring GP Signature: ___________________________________________

PATIENT DETAILS

Name: ____________________________________________________________
Address: _________________________________________________________
_________________________________________________________________
_________________________________________________________________
Tel: __________________________ Mobile: ____________________________
Date of Birth: __________________________

Referring GP Signature: ___________________________________________

PHYSICAL EXAMINATION

Breast

Axilla

Other

RIGHT

LEFT

Presenting Complaint

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

URGENT REFERRAL

☐ Discrete breast or axillary lump (unilateral, distinct, separate mass in patients over 35 years)
☐ Ulceration
☐ Skin distortion
☐ Nipple eczema
☐ Recent nipple retraction or distortion (less than 3 months)
☐ Blood-stained nipple discharge
☐ Patients with acute abscess

EARLY REFERRAL

☐ Inflammation persisting after antibiotics
☐ Persistently refilling or recurrent cyst
☐ Unilateral discharge (not blood-stained)
☐ Intractable breast pain
☐ Discrete lump in women under 35 years
☐ Asymmetrical nodularity that persists at review after menstruation

ROUTINE REFERRAL

☐ A patient whom the referring doctor considers to require a specialist opinion
☐ Minor or moderate degrees of persistent breast pain (no discrete palpable lesion)
☐ Persistent bilateral nipple discharge (not blood-stained)
☐ Routine breast imaging
☐ Other

Personal history of breast cancer: No ☐ Yes ☐ Side ____________________ Year __________
Family history of breast cancer: No ☐ Yes ☐ Who ____________________ Year __________
Previous mammogram: No ☐ Yes ☐ Where ____________________ Year __________

FOR HOSPITAL USE ONLY

Date referral received: __________________________
Appointment date: __________________________