

Breast Imaging Request

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Appointments/enquiries: 020 7908 2000 (Option 4)
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PLEASE ENSURE PATIENT BRINGS PREVIOUS MAMMOGRAMS TO APPOINTMENT

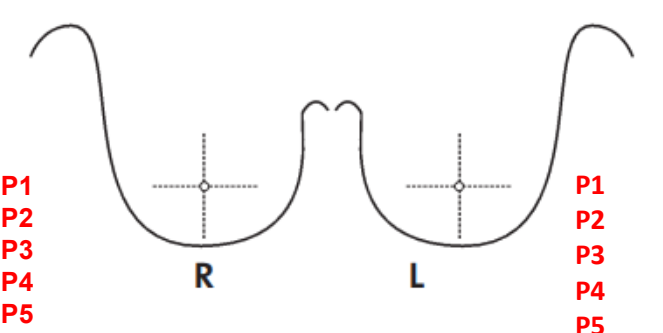
Patient Name:
DoB:/...../..... Hospital No: **X**.....
Address:
.....
Daytime Tel: Mobile:
Email:

Patient history:
(Females 12-55yrs): LMP date:
Could you be pregnant? **Y / N**
HRT? YES NO
Breast Implants? YES NO
Date of Last Mammogram
Location of Last Mammogram.....
.....
Further Details
Family history:
.....

Referring Doctor:
Address for results:
.....
Tel: Fax:
Signed by referrer:
Date:
Next appointment date:

Examination required R L Both
Mammogram
US Breast
US Axilla
Other
Please State.....

Annotate site of symptoms or exam findings



P1 P2 P3 P4 P5 R L P1 P2 P3 P4 P5

Clinical Indication:
Examinations cannot be performed without sufficient information in line with the Ionising Radiation (Medical Exposure) Regulations 2000

Radiographer:
Date:
Dose:
Comments

