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			

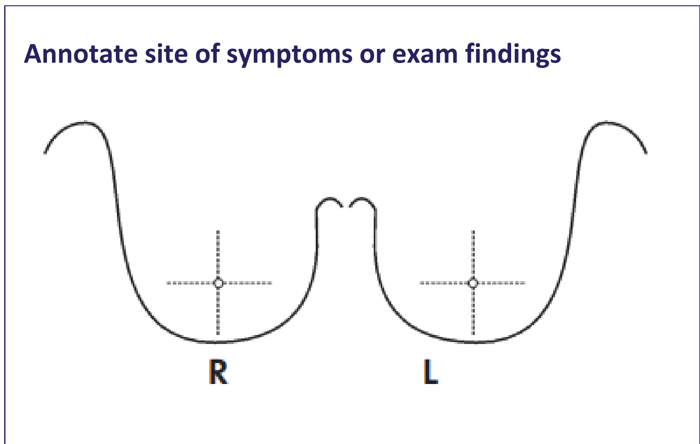
Please State..

Clinical Indication:

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

Any Previous Breast Surgery ?

Annotate site of symptoms or exam findings



Radiographer: ....
Date: ....