X-Ray & Imaging

BREAST RADIOLOGY REQUEST FORM

Please ensure previous mammograms available for appointment

Patient Details

Forename:

Surname:

Previous surname:

Date of Birth:

(Please enter patient's date of birth in the format dd-mm-yyyy)

Referring Doctor

Name:

Address: Please fill in your clinic address

Tel: Please fill in your clinic telephone number

Signature:

Date: **(dd-mm-yyyy)**

GMC Number: Please fill in your GMC number

Justified By:

Date: **(dd-mm-yyyy)**

Examination Required

	R	L	Both
Mammogram	○	○	○
US Breast	○	○	○
US Axilla	○	○	○

Other:

History

Previous Breast Surgery

Breast Implants ○ Yes ○ No

Date of Last Mammogram: **(dd-mm-yyyy)**

Location of Last Mammogram:

Family History of Cancer:

Any anticoagulant? ○ Yes ○ No

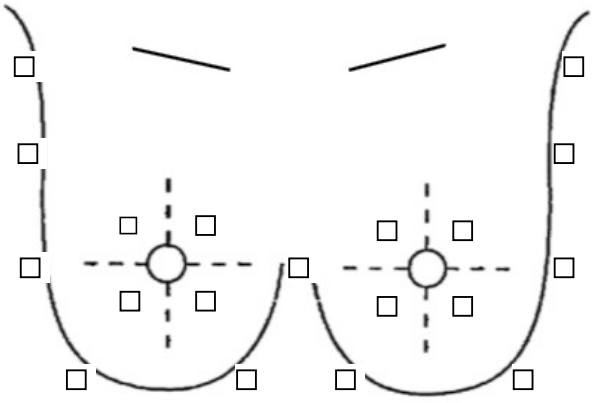
Does the patient need to stop it for 48 hours prior to exams?

○ Yes ○ No

Clinical Indication:

Annotate site of symptoms or exam findings

Please tick the areas of the breast that need examination.



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