X-Ray & Imaging

CONTRAST ENHANCED DIGITAL MAMMOGRAM REFERRAL FORM

Patient Details

Title: Mr Mrs Miss Ms Other

Name:

Date of Birth: NHS No.:

Please tick: NHS Private

Address:

Postcode:

Daytime telephone No.: Mobile No.:

Referrers Details

Name (including speciality):

Hospital Address:

Tel: Email:

Indication for contrast mammogram (CEDM):

Full clinical details:

Safety Questions

Prior contrast exam: Yes No Pregnant/ Lactating: Yes No Anticoagulants: Yes No

Diabetes: Yes No Metformin: Yes No Asthma: Yes No

Allergies: Yes No If yes, to what:

Creatinine: eGFR:

Date of Blood Test:

(Within the last 6 months) Please attach blood test report

Signature:

Date:

PLEASE IEP ALL RELEVANT BREAST IMAGING AND REPORTS TO 108 HARLEY STREET

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