Enhanced Mammography Referral

The Breast Clinic, 108 Harley Street,
London W1G 7ET
Telephone: 0 207 563 1234
Email: xray@108harleystreet.co.uk

PATIENT DETAILS		
Title:	First name:	Surname:
DOB:	NHS NO:	NHS / Private (Please circle)
Address: Postcode:		
Daytime telephone number:		Mobile telephone:

REFERRER DETAILS	
Name (including speciality):	
Hospital address:	
Telephone number:	Email address:
Indication for enhanced mammogram:	
Full clinical details:	

DO YOU HAVE A PREFERRED REPORTING RADIOLOGIST?
(If Yes) Name:

SAFETY QUESTIONS		
Prior contrast exam: YES □ NO □	Pregnant/ Lactating: YES □ NO □	Diabetes: YES □ NO □ Metformin: YES □ NO □ Asthma: YES □ NO □
Allergies: YES □ NO □ If yes, to what:	Anticoagulants: YES □ NO □	Creatinine:…… eGFR:…… Date of Blood Test:…… (Within the last 6 months) Please attach blood test report
Date:	Signature.	

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

BILL TO:
(Please fill this section for billing purposes)

Clinic ☐

Patient: Self-Pay ☐ **Insurance** ☐

Insurance Details: _____

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