



Request For Mammography / Breast Ultrasound



Department of Radiology
Direct Line: +44 (0) 20 7616 7766 Direct Fax: +44 (0) 20 7616 7690
Email: mammographycoordinator@thelondonclinic.co.uk

Referring Clinician: _____
Address: _____
Telephone Number: _____
Copy report to: _____

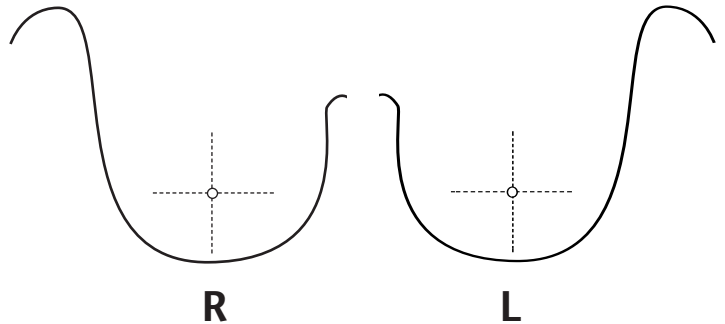
Surname: _____
First Name: _____
D.O.B. _____
Address: _____
Postcode: _____ Tel No: _____

Examination Required

Previous Breast Imaging	Mammography	Ultrasound	Other
	Bilateral <input type="checkbox"/>	Bilateral <input type="checkbox"/>	
	Unilateral R <input type="checkbox"/> L <input type="checkbox"/>	Unilateral R <input type="checkbox"/> L <input type="checkbox"/>	

Please Send X-Ray Films

Clinical Information and Findings



Previous History

Family:
Breast Cancer:
Breast Surgery:

I confirm that I am not pregnant:

Signed: _____

Radiographer: _____

Date: _____

LMP	Parity
HRT/OC	Duration
Post Menopausal	Yes / No
For department use only	R L
Total Dose	CC MLO

Referrer's Signature _____

Date _____

Radiographer's Initials _____

