Mammography Request Form

Issue **January 2021** Review **January 2024**

NEW VICTORIA HOSPITAL

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Telephone Enquiries: **+44 (0) 20 8949 9030** Fax: **020 8949 9032** Email: **imaging@newvictoria.co.uk**

Referring Clinician: _____

_____

Address: _____

_____

_____

_____

Fax no. (for results): _____

Tel no.: _____

Surname: _____

First name: _____

Date of birth: _____

Address: _____

_____

Post code: _____ **Tel no.:** _____

Hospital no.: _____

Insurance company: _____

Policy no.: _____

Clinical History (IRmER requires a full history):

☐ **New lump**

☐ **Pain**

☐ **Spontaneous nipple discharge**

☐ **Previous breast surgery** (please specify)

Family history? **Yes** ☐ **No** ☐

Other symptoms? **Yes** ☐ **No** ☐ (please specify)

_____

_____

_____

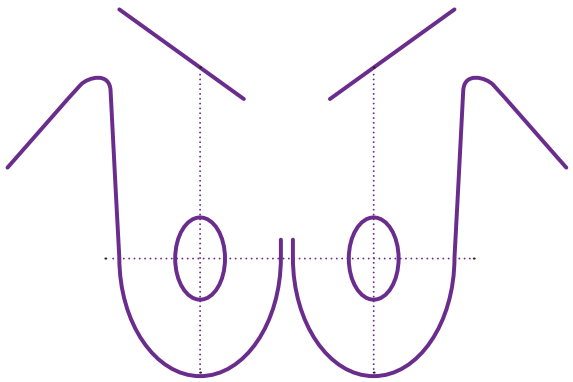
_____

_____

_____

Clinical Examination

Please, complete the form and then print it out to mark appropriately with a pen.



Test Required:

☐ **Mammogram**

☐ **Ultrasound**

☐ **Right**

☐ **Left**

☐ **Axilla**

Signature: | **Date:**

Previous imaging? **Yes** ☐ **No** ☐

Location performed:

Date/Year:

PLEASE BRING ANY PREVIOUS BREAST IMAGING FOR COMPARISON.

Patient Transport:

Inpatient ☐ **Room no.** _____

Walking ☐

Chair ☐

Bed ☐

For female patients under 55 years.

I believe that I am not pregnant at the time of this examination.

LMP Date:

Signature:

Print Name:

for Imaging Department Use Only.

Appointment Information

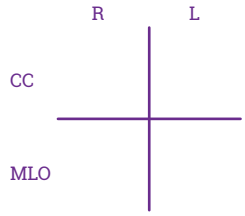
Date:

Time:

Print Name:

Radiographer Justification

Please, complete the form and then print it out to mark appropriately with a pen.



Initials:

Date: