Mammography Request Form

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

NEW VICTORIA HOSPITAL

184 Coombe Lane West, Kingston upon Thames, Surrey, KT2 7EG
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)

____

____

____

____

____

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.

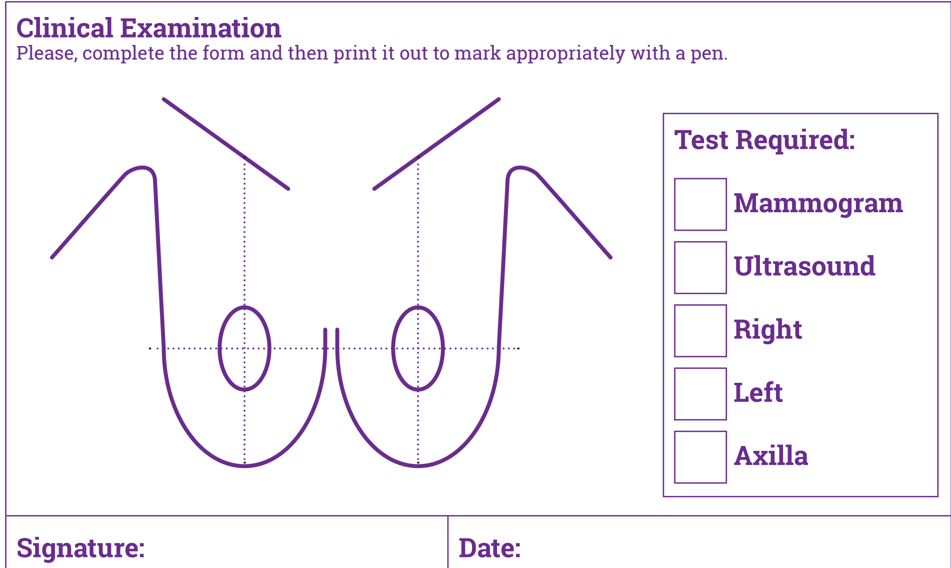
LMP Date:

Signature:

Print Name:

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:**

for Imaging Department Use Only.
Appointment Information

Date:

Time:

Print Name:

Previous imaging? **Yes** ☐ **No** ☐

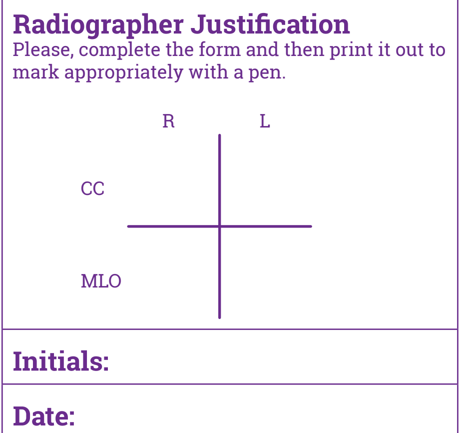
Location performed:

Date/Year:

PLEASE BRING ANY PREVIOUS BREAST IMAGING FOR COMPARISON.

Radiographer Justification

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



Initials:

Date: