

Breast Imaging Request Form

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Referring Clinician: _____	Name: _____
_____	Date of birth: _____
Address: _____	Address: _____
_____	_____
_____	Post code: _____ Tel no.: _____
_____	Hospital no.: _____
Email (for results): _____	Insurance company: _____
Tel no.: _____	Policy no.: _____

Clinical History:

Lump Pain Previous surgery Nipple discharge Family history Other

Clinical Information:

Examination Required:

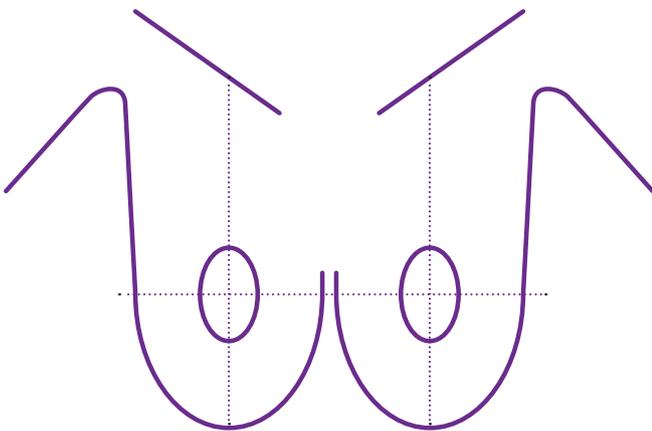
Mammogram Ultrasound MRI breast Biopsy Other _____

Laterality and details:

Previous imaging? Where: _____ When: _____ Modality: _____

Clinical Examination

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



Signature: _____ Date: _____

Booking: Date/Time: _____

For female patients under 55 years.

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

LMP Date: _____

Signature: _____

Print Name: _____

Radiographer Justification

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

	R	L
CC		
MLO		

Initials: _____

Date: _____