MAMMOGRAPHY REQUEST FORM

THE PRINCESS GRACE HOSPITAL

PLEASE SEND ALL RELEVANT IMAGING WITH PATIENT

Patient Name……………………………………..
DOB………………………………………………...
Hospital number: X……………………………
Address:……………………………………........
Daytime telephone No ……………………….
Mobile No………………………………………….

Appointment:
Date …………..
Time …………..

2nd Floor, 42-52 Nottingham Place
Tel: 020 7908 2031
Fax: 020 79082275
Email: appointments@londonbreastinstitute.co.uk

Referring Doctor: ……………………………
Address for results……………………………..
……….……………………………………………
……………………………………………………………
Tel.……………………………………......
Fax ……………………………………………..
Email ……………………………………………..
Next appointment Date …………………..…..

Hormones NO ◻ YES ◻ Details ……………………

Family History

(Include date of hysterectomy if applicable)

L M P Date:……………………………………

Examination (s) required:

Justified by……………………………………………
Radiographer...…………………………………....
Date……………………………………………….
Radiation Dose: ……………………………………

Clinical Information: Examination cannot be performed without sufficient clinical information (Ionising Radiation Medical Exposure Regulation 2000):

Date: ……………… **Doctor's Signature:** ………………..……………………

Present Clinical Findings (please mark in lesions and site of tenderness, etc)