RADIOLOGY REQUEST FORM

108 X-RAY AND IMAGING

AT

108 HARLEY STREET
LONDON W1G 7ET

Patient's Name _____

D.O.B. _____

Address _____

_____

Tel. No. _____

Referring Doctor _____

Address _____

_____

Tel. No. _____

Date _____

Insurance/Company _____

Please tick as appropriate

☐ Mammogram ☐ Breast Ultrasound ☐ X-Ray ☐ Ultrasound

EXAMINATION(S)

CLINICAL INFORMATION & DETAILS OF OTHER/PREVIOUS X-RAY EXAMS

Doctor's signature

MAMMOGRAPHY/BREAST ULTRA SOUND

AGE AT 1ST CHILD ☐☐ AT FIRST PERIOD ☐☐

PARITY NIL ☐ 1-2 ☐ 3-4 ☐ 4 PLUS ☐
(FULL term only)

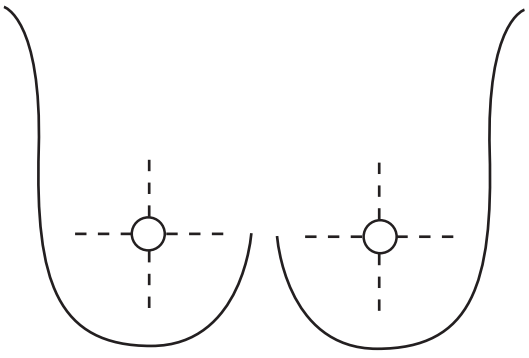
LMP _____ POST MENOPAUSAL ☐

HORMONES NO ☐ YES ☐ DETAILS _____

FAMILY HISTORY

(include date of hysterectomy if applicable)

PRESENT CLINICAL FINDINGS
(Please mark in lesions and site of tenderness, etc.)



PROCEDURE CODES

			Radiographer initials

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