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THE HARLEY·STREET BREAST CLINIC

Imaging Request Form

Patient's Name: _____

Patient D.O.B: _____ Sex: M ☑ F ☐

Patient ID No: _____ Telephone No: _____

Patient Address: _____

_____

Date of previous mammogram / ultrasound: _____

PLEASE ENSURE PATIENTS BRING ANY PREVIOUS FILMS WITH THEM ON THE DAY FOR COMPARISON

Referring Dr: _____

Referrer's contact details: (please put address / secure fax to receive patient reports)

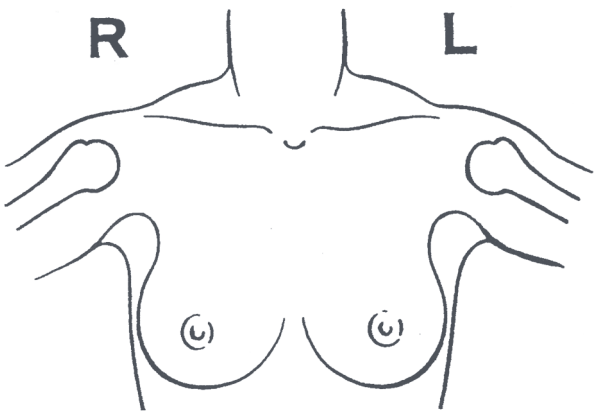
_____

_____

INVESTIGATION REQUIRED	SIDE	TICK	INVESTIGATION REQUIRED	SIDE	TICK
Bilateral Mammogram	Bilater		U/S Breast Aspiration/Cytology	Bilater	
Unilateral Mammogram	Bilater		U/S Breast Core Biopsy	Bilater	
Mag/Pad/Extra views	Bilater		U/S Breast Localisation	Bilater	
Bilateral Breast Ultrasound	Bilater		Abdominal Ultrasound	Bilater	
Unilateral Breast Ultrasound	Bilater		Cyst Aspiration	Bilater	

Other examination (please specify):

CLINICAL INFORMATION:
(Please note LMP, Symptoms, Hormones and Family hx)



(Please mark lesion and site of tenderness etc.)

Doctor's Signature:

Date: