# 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**

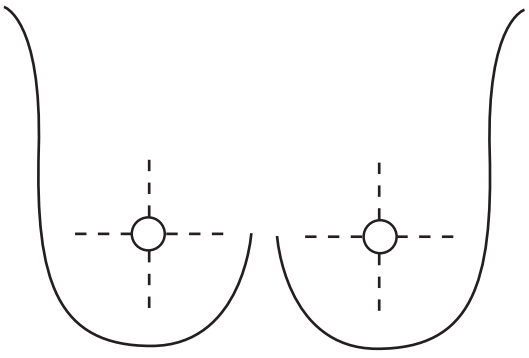
_____

_____

_____

(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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