parkside hospital

MAMMOGRAPHY REQUEST FORM

Parkside Hospital & Cancer Centre London	DEPARTMENT OF RADIOLOGY
53 Parkside Wimbledon London SW19 5NX Telephone: 020 8971 8000	Fax: 020 8947 1526 Email: radiology@parkside-hospital.co.uk

Referring Doctor	Patient Details
Doctor:	Surname:
Address:	First Names:
	D.O.B.:
	Clinic No:
	Address:
Tel No:	Tel No:

For female patients aged 12-55 years please enter date of L.M.P.

Is there any possibility you could be pregnant YES ☐ NO ☐

PLEASE TICK APPROPRIATE BOX:	I/P ROOM NO ☐	O/P ☐	WALK ☐	CHAIR ☐	STRETCHER ☐	PORTABLE ☐	THEATRE ☐

CLINICAL HISTORY (IRMER requires a full history):

☐ New Mass ☐ Pain

☐ Bloody Nipple Discharge ☐ Previous Surgery

Family history YES ☐ NO ☐

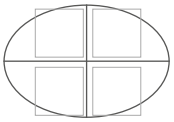
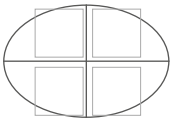
Details?

EXAMINATION REQUESTED:

☐ Screening (Asymptomatic)

☐ Diagnostic

☐ Breast Ultrasound Required

RT  LT 

SPECIFIC QUESTION TO BE ANSWERED:

SIGN	DATE	Preferred Radiologist?

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING. Patients MUST bring outside Imaging for comparison

For Radiographer use only

Comments:	Justified By:
	Dose (kVp / mAs):

DLR Reading: _____ Number of projections sent: _____ HRT? YES ☐ NO ☐

Previous Images? YES ☐ NO ☐ Where? _____ Insured? YES ☐ NO ☐

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