THE LONDON CLINIC

Breast Imaging request

PATIENT INFORMATION

*indicates mandatory fields

*TLC unit no. (if known) L

*Title

*DOB dd/mm/yyyy)

*Surname

*Forename(s)

*Sex at birth M F Gender IP OP Room

*Referrer's full name and / or practice stamp

Payment method ☐ Insurance ☐ Embassy ☐ Self-Pay ☐ Sponsor

Payment provider

Member no.

Authorisation no.

Patient's tel no.

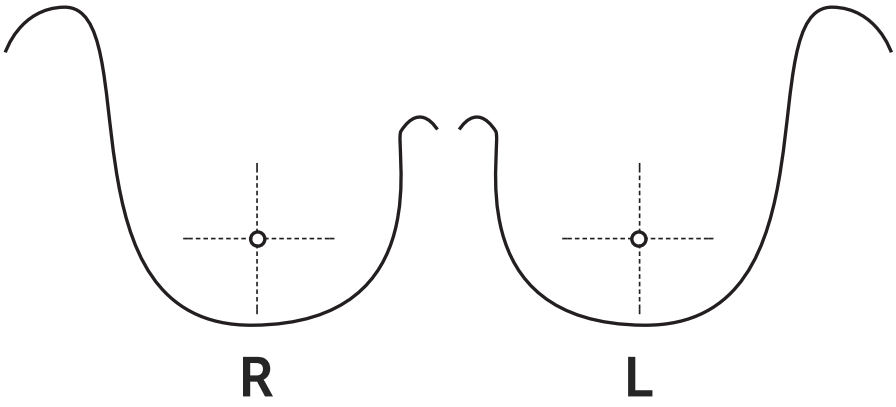
Patient's email

*Patient's address

Copy of reports to

Appointment	Mammography	Ultrasound	Breast MRI	Other
Date: Time:	Bilateral ☐ Unilateral R ☐ L ☐	Bilateral ☐ Unilateral R ☐ L ☐		
Previous breast imaging				

CLINICAL INFORMATION



Previous history
Family

Breast cancer

Breast surgery

LMP	Parity
HRT / OC Yes ☐ No ☐ Duration:	
Post menopausal Yes ☐ No ☐ Pregnant Yes ☐ No ☐ Breastfeeding Yes ☐ No ☐	R / L
Justified by Radiographer	

Preferred Radiologist:

Referrer's Declaration (N.B. This form is a legal document)

- The correct patient details have been provided.
- I have given sufficient clinical information for the request to be justified according to IR(ME)R 2017.

Referrer's signature

Date / /

A **MAIN HOSPITAL IMAGING DEPARTMENT**
7th and 8th Floor
20 Devonshire Place
London W1G 6BW

B **THE DUCHESS OF DEVONSHIRE WING IMAGING DEPARTMENT**
3T MRI, Basement Three
22 Devonshire Place
London W1G 6JA

C **IMAGING DEPARTMENT**
Lower Ground Floor
5 Devonshire Place
London W1G 6HL

X-Ray / US / Bone Densitometry / Neurophysiology / Vascular
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