Patient's Name _____

D.O.B. _____

Address _____

_____

Tel. No. _____

Referring Doctor _____

Address _____

_____

Tel. No. _____

Date _____

Insurance/Company _____

_____

108 X-RAY AND IMAGING

AT

108 HARLEY STREET
LONDON W1G 7ET

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)

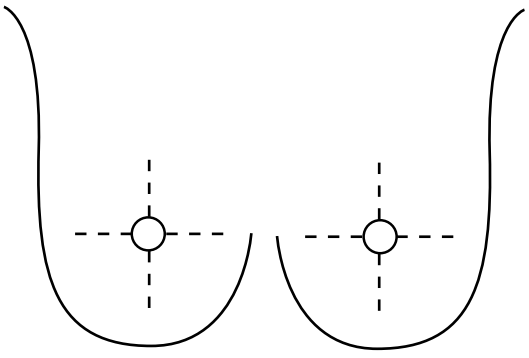
LMP _____ POST MENOPAUSAL ☐

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

Telephone 020 7563 1234 **Facsimile** 020 7563 1212 **Email** info@108harleystreet.co.uk **Web** www.108harleystreet.co.uk