

Mammography Request Form

Peregrine Road, Westhill Business Park,
Aberdeenshire AB32 6JL

Appointments Tel: 01224 515254

Email: imaging@rochealthservices.com

Website: rocprivateclinic.com



Important! Please send all previous relevant imaging with patient

Patient Details Name: _____ Date of Birth: _____ Address: _____ _____ _____ Postcode: _____ Landline/Mobile: _____ Email: _____ Preferred method of contact: Phone <input type="checkbox"/> Email <input type="checkbox"/>	Funding Self-Funded <input type="checkbox"/> UK Insurance <input type="checkbox"/> Int. Insurance <input type="checkbox"/> NHS <input type="checkbox"/> Patient's Insurance Company: _____ Membership Number: _____ Pre-authorisation Number: _____ Please note: Uninsured patients and insured patients without pre-authorisation are required to pay on the day of their appointment
---	--

Referral Details	
Type of examination required (please circle 2D or 3D):	2D / 3D
Start date of last menstrual period:	
Date of last mammogram (if any):	
Any previous breast surgery?	Yes / No
Does patient have breast implants?	Yes / No
Is patient on hormone treatment?	Yes / No
If so, provide details:	
Family history:	
Clinical Indication:	

Please note examinations cannot be performed without sufficient clinical information

Justified by: _____ Radiographer: _____ Date: _____ Dose: _____ Medication / Contrast: _____ Additional Comments: _____ _____	Present clinical findings (please mark lesions and site of tenderness etc.)
---	--

Referring Clinician Name: _____ Signature: _____ Date: _____ IR(ME)R 2000 regulations require referrals to be signed by referring clinician	Address: _____ _____ _____ Postcode: _____ Landline/Mobile: _____ Email: _____ Preferred method of contact: Phone <input type="checkbox"/> Email <input type="checkbox"/>
--	--