Breast Imaging Request Form

KINGSBRIDGE Private Hospital ★★★★★

Account number:	
Case number:	

Referrers are required to complete boxes 1-4 accurately and legibly and are legally obliged, under the Ionising Radiation (Medical Exposure). Regulations (Northern Ireland) 2000, to supply sufficient medical data to enable the practitioner to decide on whether there is a sufficient net benefit. INADEQUATELY COMPLETED FORMS WILL NOT BE ACCEPTED.

1 - Patient details

Title:		Forename:		Surname:	
DOB:		Gender: ☐ Male ☐ Female			
Address:					
Postcode:		Tel (Home):		Mobile:	
Email:					

2 - Patient category

☐ Insured ☐ Self funding ☐ Medico-legal ☐ Health Screening ☐ Immigration

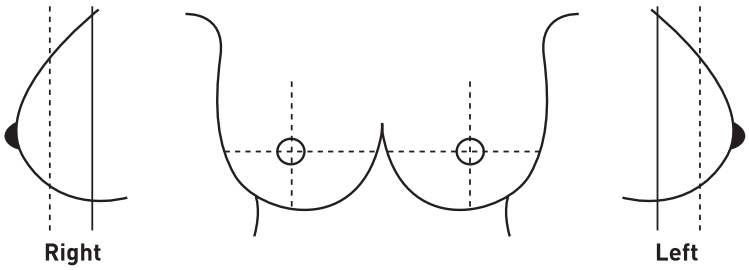
Patient Identification
For Kingsbridge Private Hospital use only.

I have confirmed the above patient's name, address and DOB. Signed:

Verified by patient: ☐ If another/status: ☐ Signed:

3 - Clinical Details

(The examination will not be performed unless sufficient clinical details are supplied.
Include date and nature of any relevant previous examination, surgery, radiotherapy/chemotherapy).



HRT: ☐ Yes ☐ No

Previous surgery: ☐ Benign ☐ Malignant

Family history: ☐ Yes ☐ No

Radiotherapy: ☐ Yes ☐ No

Previous mammogram: ☐ Yes ☐ No

When: Where:

Scars on your breasts: ☐ Yes ☐ No

Where:

Cllinical information/Reason for imaging request

Please send completed form by post, fax or email to:
Kingsbridge Private Hospital, MRI, CT and Outpatients Centre, 801 - 805 Lisburn Road, Belfast, BT9 7GX.
T: +44 (0) 28 9073 5272 | F: +44 (0) 28 9024 9929 | E: imaging@3fivetwo.com

MAM
REQUEST

4 - Mammography/Ultrasound request - Please indicate

Referring clinician (print name):		Signature		Date	
Address:					
Post Code:		Email :		Mobile	

For Radiology staff use only

Operator:		Practitioner:	

Pharmaceutical prescription and contrast administration

Name:	Strength:	Dose/QTY:	Batch # & Exp. date:	Drawn up by:	Checked by:
Prescriber's signaure:			Administed by:		

Standard Operating Procedure:		Other:	

Remarks:

Notes:

Number of images taken:		Signed:		Date:	
Disc in possession of:		Signed:		Date:	

Signed:		Date:		Chaperone:	

Consent form

I hereby consent to having further invasive imaging investigations carried out.

Signed:		Date:	
Witnessed:		Date:	

Medication: ☐ Aspirin ☐ Warafin

Further examination/investigation, authorised/justified by: _____ (Operator/Practitioner)

Please send completed form by post, fax or email to:
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