OneWelbeck Women's Health

Breast Imaging Referral Form

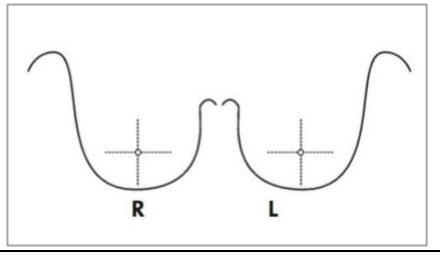
PATIENT DETAILS

TITLE:	FORENAME(S):	SURNAME:
DATE OF BIRTH:		
RESIDENTIAL ADDRESS:		POSTCODE:
TELEPHONE:	MOBILE:	EMAIL:

REFERRAL DETAIL

Examination required to be reported by:

Clinical indication for examination - please summarise relevant history, clinical findings and test results. Indicate the question that the examination should answer.



Please state when and where previous breast imaging was performed, so that it can be retrieved for comparisons.

PREVIOUS HISTORY

Family:

Breast cancer:

Radiotherapy / chemotherapy:

Breast surgery:

LMP:	Parity:	Post-menopausal : ☐ Yes ☐ No
HRT/OC:	Duration:	DEXA scan required: ☐

N.B. This form is a legal document - Referrer's Declaration :

- The correct patient details have been provided
- I have discussed the examination, including any intervention, with the patient/guardian
- I have taken into account the possibility of pregnancy
- I have given sufficient information for the request to be justified according to IR(ME)R 200
- I will ensure that the examination results are recorded in the patient's notes

REFERRER DETAILS

GP/REFERRER NAME :	GP/REFERRER PRACTICE :
GP/REFERRER CONTACT NUMBER:	GP/REFERRER EMAIL:

PAYMENT DETAILS (IF KNOWN)

☐ Bill to Patient	☐ Bill to Insurer INSURANCE COMPANY: MEMBERSHIP NO: AUTHORISATION CODE:	☐ Bill to Embassy EMBASSY: LETTER OF GUARANTEE: ☐ (Please attach)	☐ Bill to referrer AGENCY NAME:

NAME : SIGNED : DATE :

PROFESSIONAL REG NO:

Please attach the last clinic letter, any relevant test results and any additional documentation to this form and submit to us via one of the following:

E: bookings.womenshealth@onewelbeck.com **A:** OneWelbeck Women's Health, 1 Welbeck Street, London W1G 0AR **T:** +44 (0)20 3653 2008