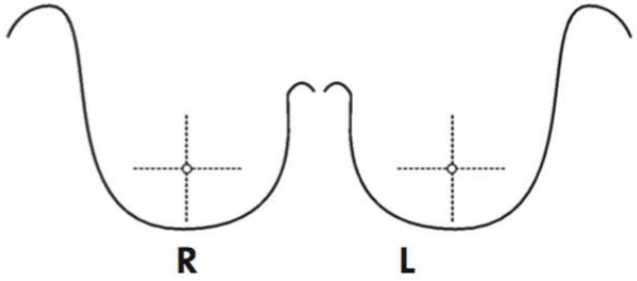
A. 1 Welbeck Street, London, W1G 0AR
T. 0203 653 2008

Email completed form to:
Bookings.womenshealth@onewelbeck.com

Enhanced Breast Screening at OneWelbeck

ALL SECTIONS MUST BE COMPLETED BY THE REFERRER

Patient Information: Please complete form in capitals using black ink and ticking/deleting as appropriate			
Title:	First Name:	Surname:	DOB:
Address:			Postcode:
Tel:	Mob:	Email:	
Insurer:	Policy No:	Pre-Auto No:	
Self-funding:			

EXAMINATION REQUIRED TO BE REPORTED BY:	
Clinical indication for examination: please summarise relevant history, clinical findings and test results. Indicate the question that the examintion shoud answer. Please state when & where previous breast imaging was performed so that it can be retrieved for comparisons.	
Previous History	**I confirm that I am not pregnant**
Family:	Signed:
Breast Cancer:	Radiographer: Date:
Radiotherapy/Chemotherapy: Breast Surgery:	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.
LMP / Parity	For department use only R / L CC MLO
HRT/OC: Yes ☐ No ☐ / Duration:	
Post Menopausal: Yes ☐ No ☐	Radiation Dose: mGy / Radiographer:

Referring Consultant/GP - PLEASE COMPLETE ALL THE CONTACT INFORMATION BELOW		
Referred by (PRINT):		Signature:
Hospital/Clinic:	Tel No:	Fax No.
Report Req by:	Email Address:	Date: