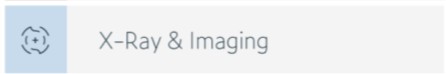
|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral form**  **Enhanced Mammography**  **The Breast Clinic, 108 Harley Street, London W1G 7ET Telephone: 0207 5631234 | Email:** [**xray@108harleystreet.co.uk**](mailto:xray@108harleystreet.co.uk) | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | |
| **Title:** | **First name:** | | | | **Surname:** | | | |
| **DOB:** | | | | **NHS NO:** | | | **NHS / Private (Please circle)** | |
| **Address:**  **Postcode:** | | | | | | | | |
| **Daytime telephone number:** | | | | | **Mobile telephone:** | | | |
| **REFERRER DETAILS** | | | | | | | | |
| **Name (including speciality):** | | | | | | | | |
| **Hospital address:** | | | | | | | | |
| **Telephone number:** | | | **Email address:** | | | | | |
| **Indication for enhanced mammogram:** | | | | | | | | |
| **Full clinical details:** | | | | | | | | |
| **DO YOU HAVE A PREFERRED REPORTING RADIOLOGIST?** | | | | | | | | |
| **(If Yes) Name:** | | | | | | | | |
| **SAFETY QUESTIONS** | | | | | | | | |
| **Prior contrast exam:** | | **Pregnant/ Lactating:** | | | | **Diabetes:** | | **YES □ NO □** |
| **YES □ NO □** | | **YES □ NO □** | | | | **Metformin:** | | **YES □ NO □** |
|  | |  | | | | **Asthma:** | | **YES □ NO □** |
| **Allergies:**  **YES □ NO □**  **If yes, to what:** | | **Anticoagulants:**  **YES □ NO □** | | | | **Creatinine:……………………………………**  **eGFR:……………………………………….** | | |
|  | |  | | | | **Date of Blood Test:…………………………. (Within the last 6 months) Please attach blood test report** | | |
| **Date:** | | **Signature:** | | | | | | |

PLEASE IEP ALL RELEVANT BREAST IMAGING AND REPORTS TO 108 HARLEY STREET

