



BERGMAN ROSS & PARTNERS RADIOLOGISTS

Practice Number: 3803465

Tel: +27 (0)21 110 5777
Suite 306, 3rd Floor, 76 Regent Rd,
Sea Point, Cape Town
For bookings contact:
ww@bergmanross.co.za



DR LEORA SWEIDAN MBCHB (UCT), FC RAD DIAG (SA) - CONSULTANT BREAST IMAGING SPECIALIST

REQUEST FOR IMAGING EXAMINATION

Date:	Date of birth:
Name:	ICD 10 Code: <input type="text"/>
Medical Aid:	Medical Aid No.:
Tariff Code: <input type="text"/>	Authorisation No.:

CLINICAL HISTORY

PREVIOUS IMAGING HISTORY YES NO

What imaging did you have: _____

Where was the imaging done: _____ What year did you have your imaging: _____

EXAMINATION REQUESTED: PLEASE TICK THE FOLLOWING

MAMMOGRAPHY
 ULTRASOUND-GUIDED CORE BIOPSY
 STEREOTACTIC-GUIDED BIOPSY
 V/MARKER PLACEMENT OR MAGSEED

BREAST MRI
 BREAST ULTRASOUND
 BMD

FEMALE PATIENTS: ARE YOU PREGNANT? YES NO

REFERRING DOCTOR: _____ EMAIL: _____

SIGNATURE: _____ TEL NO. _____

PRACTICE NO.: _____