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Well Women
BONE AND BREAST CARE

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:
Medical Aid:	Medical Aid No.
Tariff Code:	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.: _____