



# BERGMAN ROSS & PARTNERS RADIOLOGISTS

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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.: \_\_\_\_\_