Inner Images
Mobile Mammography Service

PATIENT PREVIOUS RECORD REQUEST

Patient Name______________________________Date of Birth___________________

Location & date of last mammogram____

Request: Films_________ Year_____________

Report________ Year_____________

Name of person requesting information__________________________________

Clinic Name & Address where films are to be sent___________________________

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Fax Number where report is to be faxed _________________________________

Inner Image’s staff member who completed request _______________________

Date records sent _________________________

PLEASE COMPLETE THIS FORM & FAX TO 310.586.3009