

RADIOLOGY EXAMINATION REQUEST FORM

CHARGE
TO CLINIC

CLINIC WITH
CREDIT FACILITY

YES

NO

| | | | | | |
|---|-------------------------------------|--|--------------------------------|---------------------------|-------|
| 1. NAME (IN BLOCK): | | 2. ADDRESS: | | <i>FOR OFFICE USE</i> | |
| | | | | DATE: | |
| | | | | X-RAY NO: | |
| | | | | FILM AMOUNT: | |
| | | | | APPOINTMENT: | |
| | | | | DATE: | TIME: |
| 3. RACE: | 4. IDENTITY CARD NO: | 5. SEX: | 6. DATE OF BIRTH: | 7. AGE: | |
| 8. HOSPITAL REGISTRATION NO: | | | 9. ROOM NO / CLINIC: | | |
| 10. CONSULTANT / SPECIALIST: | | | 11. DATE & TIME: | | |
| 12. CONTRAST: <input type="checkbox"/> | 13. ALLERGY: | | 14. LNMP: | 15. PREGNANT: YES / NO | |
| 16. EXAMINATION REQUESTED: | | | | | |
| <input type="checkbox"/> X-RAY | <input type="checkbox"/> ULTRASOUND | <input type="checkbox"/> MAMMOGRAM | <input type="checkbox"/> ANGIO | | |
| <input type="checkbox"/> C.T. | <input type="checkbox"/> MRI | <input type="checkbox"/> OTHERS (SPECIFY): | | | |
| AREA TO BE EXAMINED: | | | | | |
| 17. CLINICAL DATA: | | | | | |
| NAME SIGNATURE STAMP OF DOCTOR | | | | | |
| 18. RADIOLOGY REPORT: | | | | | |
| NAME SIGNATURE STAMP OF RADIOLOGIST DATE: | | | | | |