



# Radiology Examination Request Form

## Pacific Healthcare Imaging

290 Orchard Road, #07-13 & 13A, Paragon, Singapore 238859

Tel: (65) 6508 6350 Fax: (65) 6508 6351

www.phimagingcentre.com

Office Hours: MON - FRI: 8.30 am - 5.30 pm SAT: 8.30 am - 12.30 pm

### EXAMINATIONS REQUIRED

(Patients are advised to bring along relevant previous x-rays for reference)

### CLINICAL FINDINGS (Female patients 12 – 55 years, please indicate L.M.P.)

The address to change to #07-13 & 13A on the first page and as well on the map Paragon #07-13 & 13A.

\_\_\_\_\_  
Doctor's Name and Signature

\_\_\_\_\_  
Date

Clinic Name & Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date of next appointment: \_\_\_\_\_

#### FILM DESPATCH

TO BE COLLECTED - STAT FILMS WITH REPORT

TO BE DESPACHED

FAX REPORT

#### MODE OF PAYMENT

SELF PAY  BILL TO CLINIC

BILL TO GUARANTOR \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

NRIC / Passport Number: \_\_\_\_\_

Sex: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPOINTMENT DATE AND TIME: \_\_\_\_\_

Female patients: I am not pregnant.\*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
L.M.P. (if applicable)

\*Please be advised that foetal exposure to ionising radiation is not routinely recommended.

### Checklist for CT scan

Check if patient is:

Asthmatic

Diabetic

On metformin

Allergic to contrast / other drugs

If yes, please state: \_\_\_\_\_

Creatinine Value: \_\_\_\_\_ (last 30 days)

If diabetic or has history of renal disease

**FOR OFFICE USE ONLY:**

Radiographer: \_\_\_\_\_  Previous films \_\_\_\_\_

No. of Films / CD: \_\_\_\_\_  No previous films

MAMMOGRAPHY PAD OFFERED by: \_\_\_\_\_ Accepted / Refused

CT: Oral Contrast / Water

Time : 1. \_\_\_\_\_ : 2. \_\_\_\_\_ : 3. \_\_\_\_\_

IV Contrast

Type: \_\_\_\_\_ Amount: \_\_\_\_\_ ml Rate: \_\_\_\_\_ ml/s

Prescribed by: \_\_\_\_\_ Administered by: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

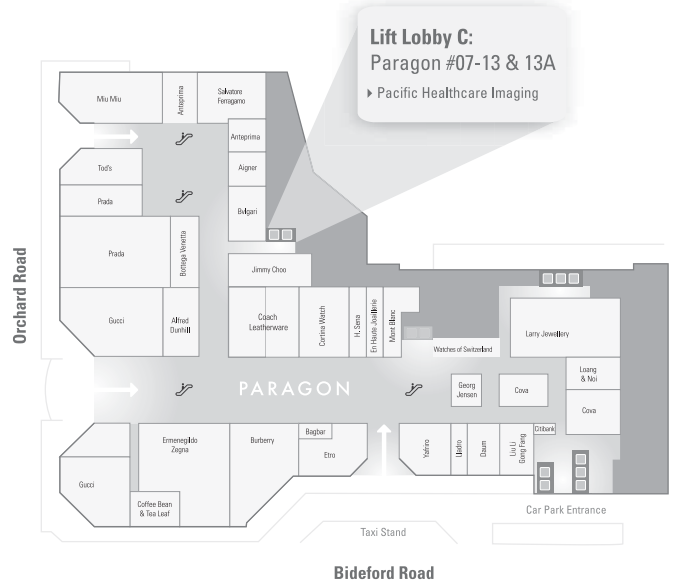
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Checklist for mammographers**

- Any family history of breast cancer?
- Any previous breast surgery/implant?
- Any breast lump/nipple discharge?



**INSTRUCTIONS:** (Not meant for infants or children - separate instructions from clinic  
 说明: (不包括婴儿及孩童, 婴孩及孩童将另别给说明) )。

	<b>Approx duration of examination</b>
<input type="checkbox"/> PELVIC ULTRASOUND Drink 4 GLASSES of water before coming to the examination. Do NOT empty bladder. 在到来检查之前, 先喝四杯水, 使膀胱充水, 别小解。	20 MINS – 60 MINS
<input type="checkbox"/> ULTRASOUND GALLBLADDER/LIVER/PANCREAS/ABDOMEN No food or drinks SIX HOURS before the examination. 在检查前之六小时, 最好不要进食或喝水。	30 MINS
<input type="checkbox"/> CT SCAN Preferably No food 4 HOURS before the examination. Small amount of clear water is permitted. 在检查前之六小时, 最好不要进食, 但可喝少量清水。	20 MINS – 60 MINS
<input type="checkbox"/> MAMMOGRAM Do not apply Talcum powder or perfume. Bring mammogram films.	1 HOUR