



# HERMITAGE MEDICAL CLINIC RADIOLOGY DEPARTMENT

PH 01 6459042/9043 FAX 01 6459128

Name:		LMP DATE:	
Address: -3		Is there any possibility this patient is pregnant	
Ph No:		Yes <input type="checkbox"/> No <input type="checkbox"/>	
DOB: M <input type="checkbox"/> F <input type="checkbox"/> (Affix label here please)		Patients Signature: _____	
Examination Requested:		Outpatient <input type="checkbox"/>	
Clinical History		Daycare <input type="checkbox"/>	
Allergies:		Ward:	
		Portable <input type="checkbox"/> Chair <input type="checkbox"/>	
		Bed <input type="checkbox"/> Walking <input type="checkbox"/>	
Ref Doctor / HMC Consultant/ GP (BLOCK LETTERS)		Notes/Comments	
Address:			
Date:	DR's Signature	Suite No	