HERMITAGE MEDICAL CLINIC
RADIOLOGY DEPARTMENT

PH 01 6459042/9043 FAX 01 6459128

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

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