विकिरण नैदानिक विभाग

अ० भा० आ० सं०, नई दिल्ली-११००२६

DEPARTMENT OF RADIODIAGNOSIS

A.I.I.M.S., NEW DELHI - 110029

PLAIN X-RAY/CONTRAST STUDIES REQUISITION FORM

Name : Sunita Singh **Age/Sex :** 30 yr / F **Ref. Deptt./Unit :** 2019 / Dec / 304 **Date :** 2/04/17

Indoor (Bed No.) / Outdoor/ Casualty **UHID No. :** 100638089 **LMP :**

Examination Required :

Clinical History and Examination : FUC Lt MRM on 2012

Fu Rt. mamogram.

Clinical / Working Diagnosis :

Blood Urea / S. Creatinine :
Any h / o allergy or asthma :
(for IVU patients only) :

Signature of Referring Physician / Date : Sh Sunil,

Consent :

I hereby give consent for the performance of any diagnositc or therapeutic radiological procedure with or without the use of contrast injection and / or sedation. The associated complications and risks have been explained to me.

Signature of Patient / Date :

Your appointment is on : _____ Room No. : _____

Time Slot : 8:30 9:00 9:30 10:00 10:30 11:00 11:30 12:00 12:30

X- Ray No. : Size / No. of Films

Date : Kvp/mAS :

Sign. of Radiographer :

P.T.O.