विकिरण नैदानिक विभाग

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DEPARTMENT OF RADIODIAGNOSIS

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

ULTRASOUND/COMPUTED TOMOGRAPHY REQUISITION FORM

Name : Sunita Singh Age/Sex : 30/F Ref. Deptt./Unit : Gyn I Date : 21/3/17

Indoor (Bed No.) / Outdoor/ Casualty Gyn OPD No. / UHID No. : 100638084 LMP : 26/2/17

Examination Required :

Ultrasound pelvis. for uterus, ET, adnexa Doppler (Arterial / Venous) Interventional Procedure

CT HRCT Dual Phase CT CT Angiography

Clinical History and Examination :

premature ovarian failure

H/o MRM for cesarean

and on Tamoxifen regularly daily

: 4½ years.

Clinical / Working Diagnosis :

Any Previous Studies (Please provide No. if available) :

Blood Urea / Serum Creatinine (for CT patients only) :

Any h/o allergy or asthma :

Signature of Referring Physician / Date :

Consent :

I hereby give consent for the performance of any diagnostic 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 :

US / CT Number : No. of Films used :

Signature of Radiographer / Date :