

**X-Ray,
Ultrasound**

APEXMED PTE LTD

7 Tanjong Pagar Plaza, #02-103, Singapore 081007

M +65 9369 7878

Appointment Date

Appointment Time

Name of Patient: _____ NRIC/Passport No.: _____

Address: _____

Age: _____ Sex: _____ D.O.B.: _____ Tel No.: _____

RADIOLOGICAL EXAMINATION REQUESTED.

X-Ray No.: _____

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

SIGNIFICANT CLINICAL FINDINGS. (Female patients 12-55 years, please include L.M.P. _____)

Referring Doctor's Name & Signature

Date

CLINIC NAME & ADDRESS:

REPORT

MODE OF PAYMENT

- ☐ Collection by Patient
☐ Soft copy to Clinic

- ☐ Self Pay
☐ Bill to Clinic
☐ Bill to Managed Care
Membership No. _____

Radiographer's
Initial: _____

Receptionist: _____

FOR FEMALE ONLY

I have been advised that this radiological procedure may have an adverse effect on a foetus and I hereby warrant that **I AM NOT PREGNANT**

Name

Last Menstrual Period

Signature/Date

Please be punctual for your appointments.
Please TICK and INSTRUCT accordingly

INSTRUCTIONS (Not meant for infants or children-
separate instructions from clinic)

**Approximate duration
of examination**

☐ **ULTRASOUND PELVIS/ BLADDER(KUB)/ PROSTATE**
Drink 4 **GLASSES** of water before coming to the examination.
Do NOT empty bladder.

30 MINS

☐ **ULTRASOUND ABDOMEN/HBS/ GALL BLADDER/ LIVER/ PANCREAS**
No food and drinks **6 HOURS** before the examination.

30 MINS

MEDICAL HISTORY

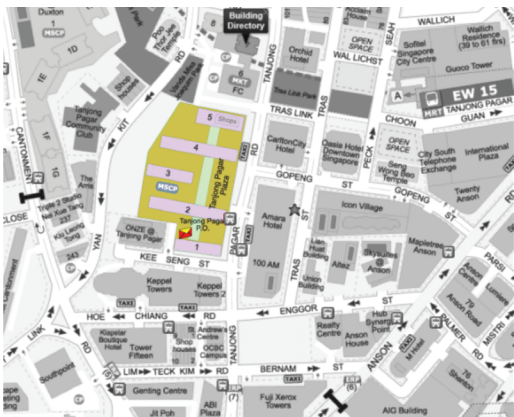
- ☐ Pregnant
☐ Hypertension
☐ Diabetes Mellitus
☐ Claustrophobia
☐ Renal Impairment

PREVIOUS OPERATION ☐ Yes ☐ No

- ☐ Intravascular Stent
☐ Cardiac Pacemaker
☐ Valvular Replacement
☐ Orthopaedic Implant
☐ Aneurysm Clips
☐ Cochlear Implant

ALLERGY HISTORY ☐ Yes ☐ No

- ☐ Asthma
☐ Sea Food Allergy
☐ Contrast Allergy
☐ Drug Allergy



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By Bus: 80, 145 (Bus Stop B05411)

By Car:
New Bridge Road - Keong Saik Road
AYE (Exit 14) - Penjur Road

By MRT:
Tanjong Pagar Station (EW15) - 5 minutes
walk from Exit A

FOR OFFICE USE ONLY

Date: _____ Time: _____

RADIOGRAPHER'S NOTE: _____