Parkway Radiology

www.parkwayradiology.com.sg

(65) 6388 4333
(65) 8798 8008
info@parkwayradiology.com.sg

APPOINTMENT DATE / TIME: _____
Please arrive at least 15 minutes prior to appointment time.

NEXT CLINIC APPOINTMENT DATE / TIME:

NAME:

DOB/Age:

NRIC/PP No:

Sex:

Nationality:

Tel:

Email Address:_____

Address:_____

_____

_____

Please scan for more information about our locations and examination instructions.

Radiology Department

☐ Mount Elizabeth Orchard (Level 2)	Fax: 6732 3368
☐ Mount Elizabeth Novena (Level 2)	Fax: 6933 0526
☐ Gleneagles (Annexe Block, Level 1)	Fax: 6470 5749
☐ Parkway East (Level 1)	Fax: 6340 8670

Radiologic Clinic

☐ Mount Elizabeth Medical Centre (Orchard)	
☐ #01-01/02	Fax: 6235 5279
☐ #02-06 to 08	Fax: 6836 4027
☐ Paragon #07-04/05/06 (Lobby E/F)	Fax: 6732 5933
☐ Mount Elizabeth Novena #01-03/04/05	Fax: 6266 3085
☐ Gleneagles #02-25/26 (Hospital Lobby/Opposite Starbucks)	Fax: 6471 1151
☐ 130 Jurong Gateway Road #01-219	Fax: 6569 7593
☐ Republic Plaza #02-10	Fax: 6908 4535
☐ Bedok (210 New Upper Changi Road #01-707B)	Fax: 6477 0254

☐ Mobile Mammography Services (YR4009J)
☐ Bedok ☐ Jurong ☐ Others _____

Opening Hours: MON - FRI: 8.30 am - 5.00 pm SAT: 8.30 am - 1.00 pm
(Bedok, Jurong and Republic Plaza clinics are closed for lunch from 1-2pm)

EXAMINATIONS REQUIRED Please write clearly and use approved abbreviations where required only
(Patients are advised to bring along relevant previous scan results in a compatible digital format (i.e. USB, CD, DVD) for reference.)

_____

_____

_____

_____

_____

CLINICAL FINDINGS (For female patients, please indicate LMP if relevant.)

_____

_____

_____

_____

Special Instructions from Clinic (if any):

_____

_____ _____ _____

Doctor's Name and Signature | Clinic Name & Address | Date

MODE OF PAYMENT	IMAGES	RESULTS
☐ SELF PAY	☐ USB	☐ STAT FILMS
☐ BILL TO CLINIC	☐ DVD	☐ TO BE COLLECTED
☐ BILL TO _____	☐ FILMS	☐ TO BE DESPATCH
	☐ E-PORTAL ONLY	

FOR RADIOLOGY USE ONLY
☐ COLLECT ☐ DESPATCH
DATE / TIME: _____
☐ STAT FILM TAKEN BY: _____

☐ Previous DVD/films (_____ DVD /_____ film sets)
☐ No previous DVD/films
Name of receiving staff: _____

Radiology Staff Notes (if any):

By providing the information set out in this form, I consent to IHH Healthcare Singapore, their representatives, agents, service providers, affiliates and/or business partners collecting, using and disclosing my personal data to provide me with medical treatment and other reasonably related purposes. Such purposes are set out in the IHH Healthcare Singapore Data Protection Notice, accessible at https://www.ihhhealthcare.com/singapore/data-protection-notice (a copy can be provided upon request). I acknowledge that I have read and agree to the IHH Healthcare Singapore Data Protection Notice.

I understand that I may withdraw such consent at any time via unsubscribe facilities OR forms available on request from our IHH Healthcare Singapore staff OR by email to IHH Healthcare Singapore DPO at pdpo@ihhhealthcare.com.

Patient's Signature _____ Date _____

PATIENT LABEL

X-Ray Label | X-Ray Label

X-Ray Label | X-Ray Label

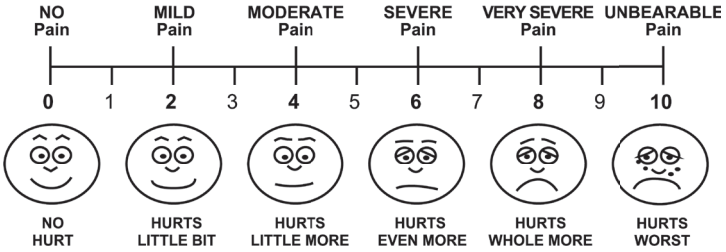
X-Ray Label | X-Ray Label

FOR RADIOLOGY USE ONLY:

I. Fall Risk Screening

☐ Low fall risk ☐ High fall risk & preventive measure advised

Screened by: _____



II. Pain assessment done by: _____

III. Height: _____ Weight: _____

IV. Patient has received an explanation on:

_____ by _____ on _____

_____ by _____ on _____

_____ by _____ on _____

_____ by _____ on _____

_____ by _____ on _____

DECLARATION BY FEMALE PATIENT (9 - 60 years old) UNDERGOING RADIOLOGICAL EXAMINATION

Please be advised that foetal exposure to ionising radiation is not routinely recommended.

My last menstrual period (LMP) is: _____. I am certain I am not pregnant.

Signature: _____ Date: _____

The radiographer/technologist will guide you through the following section if your LMP exceeds the safety period.

Please scan the QR code for information regarding Pregnancy and Radiation.

I have read about Pregnancy, Radiation and its related risks. I understand the information provided and explained to me.

☐ I am certain I am NOT PREGNANT. I have discussed with my referring doctor and agree to proceed with the radiological examination; and

- ☐ I decline a urine pregnancy test for confirmation; or
- ☐ I have taken a urine pregnancy test and the result is negative

OR

☐ I am PREGNANT and I have discussed with my referring doctor to proceed with the radiological examination.

By signing below, I attest that the above statements are true and I take full responsibility for my declaration.

Signature: _____ Date: _____

I am: ☐ Patient ☐ Relative/Guardian* (Name _____ Relationship to patient: _____)

FOR RADIOLOGY USE ONLY:

Staff name: _____ Signature: _____ Interpreter by (if any): _____

If patient is PREGNANT OR UNSURE, Radiologist is to be informed.

Radiologist name: _____ Remarks: _____

For minors without any relative or guardian companion and information is obtained via phone call

Name of person spoken to: _____ Relationship to patient: _____

Witness (Staff name): _____ Remarks: _____

*For minors, the department/clinic reserves the discretion to obtain the information from the parent, next-of-kin or guardian of the patient.