REQUEST FOR DIAGNOSTIC RADIOLOGY SERVICES AT SINGHEALTH POLYCLINICS

Ultrasound services are only available at Bedok, Eunos, Outram, Punggol and Tampines Polyclinic. Make an appointment before visit.

Operating Hours:
Mon – Fri: 8.30am – 1.00pm
and 2.00pm – 4.30pm
Sat: 8.30am – 12.30pm

☐ SingHealth Polyclinics - Bedok
11 Bedok North Street 1,
#03-01 Heartbeat@Bedok
Singapore 469662
Tel: 6202 1048
Fax: 6446 7052

☐ SingHealth Polyclinics - Bukit Merah
Blk 163 Bukit Merah Central
#04-3565
Singapore 150163
Tel: 6350 7413
Fax: 6272 6220

☐ SingHealth Polyclinics - Eunos
1 Chin Cheng Ave
Singapore 429400
Tel: 6372 6890
Fax: 6290 6395

☐ SingHealth Polyclinics - Marine Parade
Blk 80 Marine Parade Central
#01-792
Singapore 440080
Tel: 6350 7316
Fax: 6348 2024

☐ SingHealth Polyclinics - Outram
3 Second Hospital Avenue,
#04-03, Health Promotion Board Bldg,
Singapore 168937
Tel: 6350 7395
Fax: 6435 6171

☐ SingHealth Polyclinics - Pasir Ris
1 Pasir Ris Drive 4
#01-11
Singapore 519457
Tel: 6350 7332
Fax: 6585 2524

☐ SingHealth Polyclinics - Punggol
681 Punggol Drive
#02-01
Singapore 820681
Tel: 6718 2094
Fax: 6444 0682

☐ SingHealth Polyclinics - Sengkang
2 Sengkang Square
Sengkang Community Hub
#01-06
Singapore 545025
Tel: 6350 7378
Fax: 6343 8755

☐ SingHealth Polyclinics -Tampines
1 Tampines Street 41
Singapore 529203
Tel: 6350 7347
Fax: 6783 0157

Name : _____

NRIC : _____ Age & Gender: : _____

Contact No. (Patient) : _____ Contact No. (Next-of-Kin) : _____

Address : _____

INVESTIGATION REQUIRED

CLINICAL DIAGNOSIS / RELEVANT HISTORY

1. **Do you require a copy of the printed film and report?** ☐ **YES** ☐ **NO**
2. **Do you have the access to NEHR?** ☐ **YES** ☐ **NO**

_____ Name of Referring Doctor / Date

_____ Clinic Address (Stamp)

_____ Signature of Doctor

_____ Contact Number

FOR PREGNANCY RULE

I have been advised that this radiological procedure may have adverse effect on the foetus and I hereby confirm that I am not pregnant.

_____ Signature of Patient/ Date

LMP : _____

FOR INTERNAL USE

APPOINTMENT

Date : _____

Time : AM/PM

Room : _____

Radiographer's notes:

No. of Images / CD / films:

Radiographer Initial: _____

Patient's sticker:

***Authorization for collection of X ray film and/or report**

I, _____ (Name of Patient) , _____ (NRIC/FIN/Passport No.) , authorize

_____ (Name of Proxy) , _____ (NRIC/FIN/Passport No.) , to collect

the X ray film and / or report on my behalf.

I hereby acknowledge the receipt of x-ray film and/or report

Name in full : _____
(Patient / Proxy)

Signature : _____ Date : _____

* The Authorization section to be duly completed and signed by patient to transfer his/her right to collect the X Ray films if he/she is not able to. Proxy's original photo identification card such as NRIC/Passport has to be presented upon collection of the film.
We reserve the right not to release the x-ray images to a proxy if Section IV is not completed and photo identification not presented.