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.

☐ SingHealth Polyclinics - Bedok
11 BEDOK NORTH ST 1
02-01/#03-01 HEARTBEAT @ BEDOK
SINGAPORE 469662
Tel: 6202 1048
Fax: 6446 7052

☐ SingHealth Polyclinics - Bukit Merah
BLK 163 BUKIT MERAH CENTRAL
04-3565/3575
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
80 MARINE PARADE CENTRAL
01-792, #02-101/103
SINGAPORE 044080
Tel: 6350 7316
Fax: 6348 2024

☐ SingHealth Polyclinics - Outram
BLK 3 SECOND HOSPITAL AVENUE
00-00
LEVEL 2 HEALTH PROMOTION BOARD BUILDING
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 OASIS TERRACES
SINGAPORE 820681
Tel: 6718 2094
Fax: 6444 0682

☐ SingHealth Polyclinics - Sengkang
2 SENGKANG SQUARE # 01-06
SENGKANG COMMUNITY HUB
SINGAPORE 545025
Tel: 6350 7378
Fax: 6343 8755

☐ SingHealth Polyclinics -Tampines
1 TAMPINES STREET 41
TAMPINES POLYCLINIC
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:	Patient's sticker:
No. of Images / CD / films: Radiographer Initial: _____	

***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.