

JAI PRAKASH NARAYAN APEX TRAUMA CENTRE

विकिरण नैदानिक विभाग

अ. भा. आ. सं., नई दिल्ली-११००२६

DEPARTMENT OF RADIODIAGNOSIS

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

PLAIN X-RAY/CONTRAST STUDIES REQUISITION FORM

Non-MCC

Name : Age/Sex : Ref. Deptt./Unit : Date :

Indoor (Bed No.) / Outdoor/ Casualty OPD No. / CR No. : LMP :

Examination Required :

Clinical History and Examination :

Clinical / Working Diagnosis :

Blood Urea / S. Creatinine :
Any h / o allergy or asthma :
(for IVU patients only) :

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 :

Your appointment is on : _____

Room No. : _____

Time Slot : 8:30 9:00 9:30 10:00 10:30 11:00 11:30 12:00 12:30

X- Ray No. :

Size / No. of Films

Date :

Kvp/mAS :

Sign. of Radiographer :