RadLink
diagnostic imaging

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☐ **RadLink Diagnostic Imaging (S) Pte Ltd**
290 Orchard Road #08-08, Paragon (Tower 1 Lobby E/F) Singapore 238859
Tel: (65) 6836 0808 Fax: (65) 6836 8484

☐ **RadLink Women Imaging Pte Ltd**
290 Orchard Road #15-04, Paragon (Tower 1 Lobby F) Singapore 238859
Tel: (65) 6836 0808 Fax: (65) 6738 5133

☐ **RadLink (Novena) Diagnostic Imaging Pte Ltd**
101 Irrawaddy Road #10-01 to 05, Royal Square @ Novena Singapore 329565
Tel: (65) 6836 0808 Fax: (65) 6565 7288

Alternatively, you may email us your referral forms to forms@radlink.com.sg

**Operating Hours: Monday - Friday: 8.30am - 5.30pm Saturday: 8.30am - 12.30pm**

**Radiological Examination Required**

**Clinical Findings**

**Asthma** ☐ **No** ☐ **Yes**
**Diabetes** ☐ **No** ☐ **Yes**
**Drug Allergy** ☐ **No** ☐ **Yes** **Remarks:**

**Appointment Date** **Appointment Time**

Full Name (Per NRIC/ Passport):

NRIC / Passport No:

Nationality:

Date of Birth/ Age:

Sex:

Contact Number:

Local Address:

| Images | Results | Mode of Payment |
|---|---|---|
| ☐ DVD<br>☐ USB (For MRI & CT only)<br>☐ Films<br>☐ E- Portal Only | ☐ To be Collected<br>☐ To be Despatched | ☐ Self Pay<br>☐ Bill to Clinic<br>☐ Bill Guarantor / Insurer<br>Visit Number:_____ |

Patient's Next Appointment With Referring Doctor

Date Time

Doctor's Name:

Clinic Name:

Clinic Address:

Contact Number:

Doctor's Signature and Clinic Stamp:

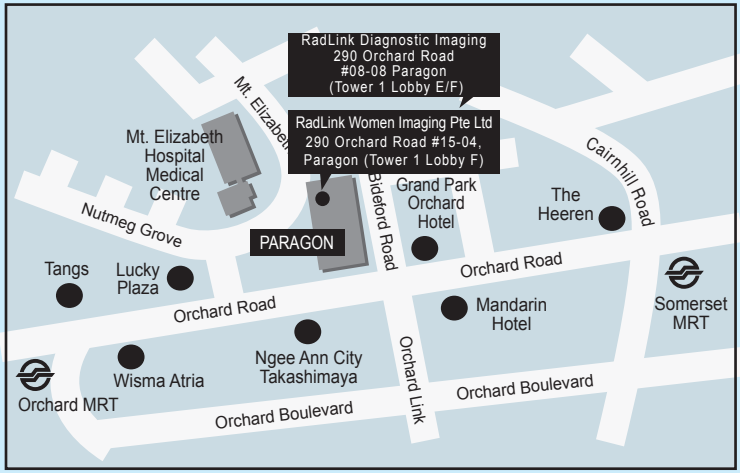
Date:

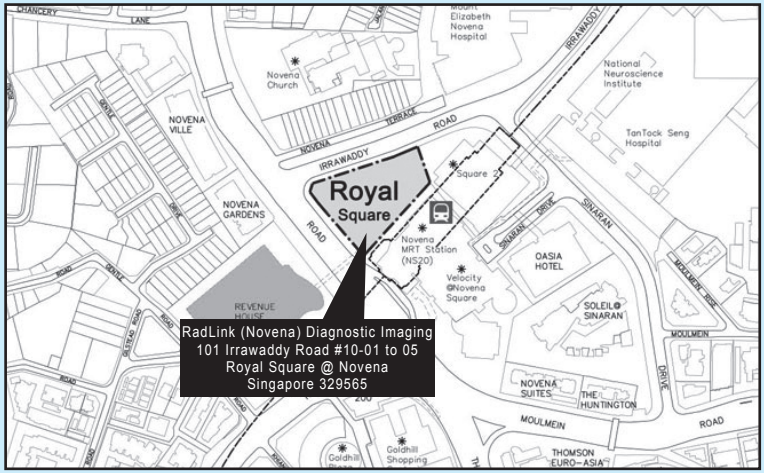
Radiographer's Remarks:

Old Films for comparison: ☐ Yes ☐ No How many copies:_____

**Scan to Download Patient Portal**

**Scan to Visit Our Website**




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:_____ NRIC/Passport No:_____

For female patients please indicate Last Menstrual Period if relevant:_____

Remarks:_____

Signature / Date: