RadLink
diagnostic imaging

- ☐ **Dr Cheryl Lim** MBBS, M Med, FRCR
- ☐ **Dr Choong Chih Ching** MBChB (NZ), FRCR (UK)
- ☐ **Dr Eng Chee Way** MBBS, M Med, FRCR
- ☐ **Dr Gi Ming Tye** MBBS, M Med, FRCR
- ☐ **Dr Lee Chin Hwee** MBBS, FRCR (UK), Med (Diagnostic Radiology)
- ☐ **Dr Lenith Cheng** MBBS, FRCR, M Med, FAMS
- ☐ **Dr Niketa Chotai** MBBS, MD, FRCR, FUOT (Canada)
- ☐ **Dr Yong Yan Rong** MBBS, M Med, FRCR

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

☐ **RadLink Diagnostic Imaging (Camden)**
One Orchard Boulevard, Camden Medical #16-03 to 06 Singapore 248649
Tel: (65) 6836 0808 Fax: (65) 6341 5787

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

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

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	☐ To be Collected	☐ Self Pay
☐ USB (For MRI & CT only)	☐ To be Despatched	☐ Bill to Clinic
☐ Films		☐ Bill Guarantor / Insurer
☐ E- Portal Only		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:

For Office Use Only:

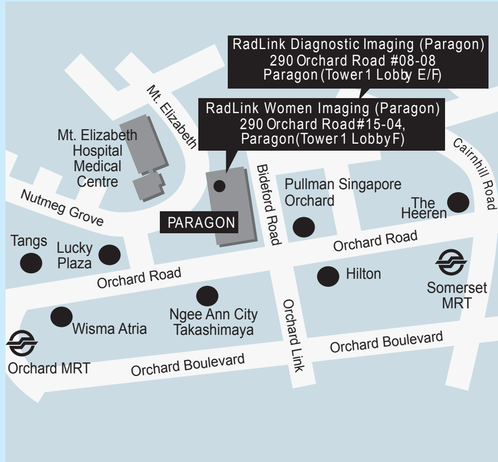
Old Films for comparison: ☐ Yes ☐ No

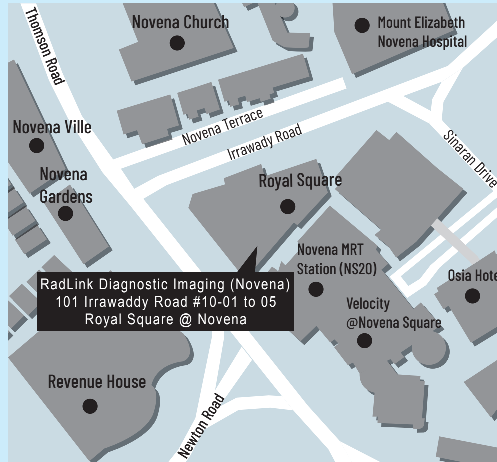
How many copies:____________

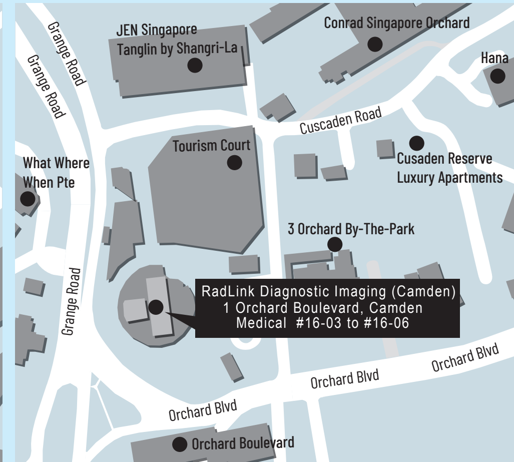
Received by:____________

TÜV SÜD ISO 9001
CERT NO.: XX-X-XXXX
ISO 9001 : 2008

Please scan the QR code for directional guide







<u>To be completed by the patient:</u>

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:____