RadLink
diagnostic imaging

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

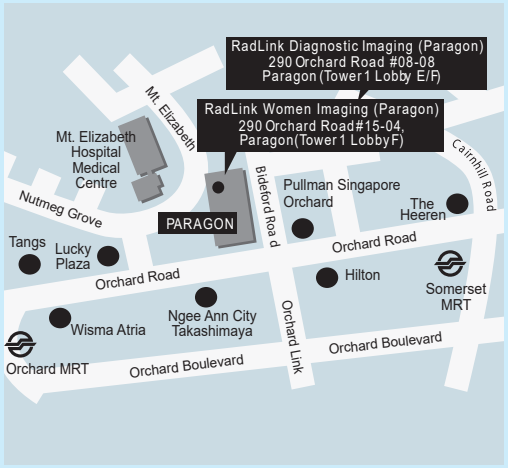
Date:

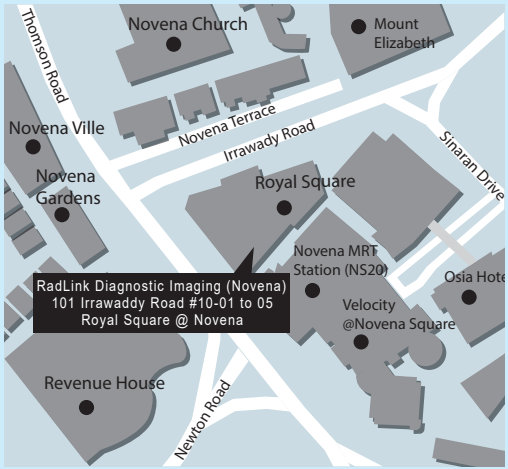
For Office Use Only:

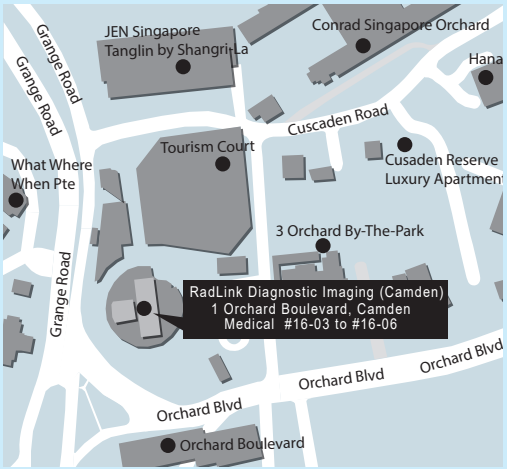
Old Films for comparison: ☐ Yes ☐ No How many copies:_____

Received by:_____

Please scan the QR code for directional guide







To be completed by the patient:

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:_____