REQUEST FORM FOR MEDICAL IMAGING EXAMINATION

A separate request form is required for each clinical issue.

RADIOLOGIE LA CAMBRE

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Patient Identification (fill in or attach label)

Name : Surname :

Date of birth :

Sex : ☐ Female ☐ Male

Relevant Clinical Information

Explanation of the Diagnostic Request

Additional Relevant Information

☐ Allergy : …… ☐ Diabete ☐ Renal insuffisiency ☐ Grossesse ☐ Implant

☐ Other : ……...

ULTRASOUND

☐ Upper abdomen – total
☐ Liver – Gallbladder – Bile ducts
☐ Kidneys – Bladder
☐ Female pelvis ☐ Endocavitary
☐ Male pelvis
☐ Prostate via endorectal approch
☐ Scrotum
☐ Thyroid
☐ Soft tissues : ……
☐ Muscles : ……

DOPPLER - ULTRASOUND

☐ Region :
……

SENOLOGIE

☐ Mammography ☐ Complete breast imaging
☐ Ultrasound
☐ Fine needle aspiration ☐ Microbiopsy

X-RAY

Region : ……..

☐ Right ☐ Left

INTERVENTIONAL

Region : …….. ☐ Thyroid puncture
Evacuation of : …… ☐ Corticosteroids **(To be prescribed)**
Injection (region):…… ☐ Hyaluronic Acid **(To be prescribed)**
☐ PRP

CONE BEAM CT

☐ Sinus – facial bones
☐ Dentalscan (Region) : ……..
☐ Limb (sans contraste)
☐ Arthro-CT (Region) : ……..

☐ BONE DENSITOMETRY

☐ Other : ……

Previous Relevant Examinations for Diagnostic:

☐ X-RAY ☐ CT ☐ MRI ☐ US ☐ Other :……...

Prescribing doctor's stamp (Name, surname, adress, INAMI)

Date :

Signature :

ANY STATE OF PREGNANCY MUST BE REPORTED BEFORE ANY EXAMINATION