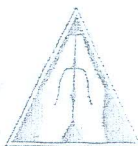




FAITH MEDIPLEX

1, Giwa-Amu / Airport Road,
P.O. Box 4307, Benin City.
Tel: 052 - 07067403594



ULTRASOUND REQUEST FORM

SURNAME _____

OTHER NAMES _____

SEX _____ AGE _____

ADDRESS _____

DATE _____

CLINICAL INFORMATION

EXAMINATION REQUIRED (Please tick appropriate box)

- ☐ GENERAL ABDOMINAL SCAN
- ☐ UPPER ABDOMINAL SCAN
- ☐ RENAL SCAN
- ☐ ADRENAL SCAN
- ☐ PELVIC SCAN
- ☐ OBSTETRIC SCAN
- ☐ GYNAECOLOGICAL SCAN
- ☐ FOLLICULAR MONITORING
- ☐ SCROTAL / TESTICULAR SCAN
- ☐ BREAST SCAN
- ☐ THYROID SCAN
- ☐ SUBCUTANEOUS / DEEP SOFT TISSUE
- ☐ ABSCESS LOCALISATION
- ☐ PLEURAL SCAN
(PLEURAL EFFUSION)

PICTURE REQUIRED?

☐ YES

☐ NO

Doctor's Signature