(1000

OIL INDIA LIMITED HOSPITAL

P.O. DULIAJAN- 786 602, ASSAM (INDIA)
E-mail : medical@oilindia.in

DEPARTMENT OF RADIOLOGY

ULTRASONOGRAPHY / CT SCAN REQUISITION FORM

Free / Bill / Paying :.......................................Date :........................Routine / Urgent :..............

Patient's Name :..Karobi Baruah..........................

Wife / Husband / Son / Daughter / Mother / Father / Servant of :..

Department :......................................SC / Regn. No. :..NEP...............OPD / Ward................

Age :.. Sex :..PID No. :...................................

Referred by Dr. :..

Clinical Note and Diagnosis :..............Early preg..

Service Required :..............................USG (Level I anomaly scan + cervical length).

2
12/8

FOR USE OF RADIOLOGY DEPARTMENT

Scan No. :.. Date :......12/8/25..............................

G.I. 99025608
(DPW/24)