BERMUDA HOSPITALS BOARD

DEPARTMENT OF RADIOLOGY

WARD

SURNAME .... Maiden Name ....

FIRST NAMES .... D.O.B. ....

ADDRESS .... Doctor ....

....

.... Chart No. ....

OUT-PATIENTS ONLY

INSURANCE COMPANY | POLICY NO. | CERTIFICATE NO.

APPOINTMENT DATE: | TIME:

BRIEF HISTORY AND
CLINICAL DIAGNOSIS

Please sign 10 day rule

observe ____________________

ignore ____________________

PLEASE INITIAL

Pt. Mode of Transport

Wheelchair ____________________

Bed ____________________

Walking ____________________

Pt. Accompanied by Nurse

Yes __________ No __________

Special Instructions

____

PLEASE X-RAY

1.
2.
3.
4.

Date of request

Doctors Signature

S20001 E.L.