	Lilongwe Institute of Orthopaedics and Neurosurgery **Department of Radiology** **<u>US and X-ray examination REQUEST FORM</u>**

	Date of Requisition	
	Surname	First name
Patient name		
Date Of Birth		
Sex		
Weight		kg

Referral ward/department	
Referring doctor (PLEASE PRINT)	
Phone number	

Requested examination	
Requested time of examination	☐ Routine ☐ Urgent

Clinical findings and short history:

Provisional diagnosis:

Signature: ____