



AMINU KANO TEACHING HOSPITAL, KANO

RADIOLOGY REQUEST CARD

Surname	First Names	Age	Sex	Hospital No:	X-RAY/USS/CT No:
Address		Occupation		L.M.P.	
Consultant:	Name of Requesting Doctor:		Investigation Requested:		

Clinical Details:



DATE

SIGNATURE

RADIOGRAPHER'S NAME

43 X 35 cm _____

35 X 35 cm _____

40 X 30 cm _____

40 X 15 cm _____

30 X 24 cm _____

24 X 18 cm _____

DENTAL _____

OCCLUSAL _____

Room _____

Dist _____

M.A _____

Time _____

K. V. P _____

Screens _____

Office Use:-

Date of Examination



Films Checked by: