31-001

LUNG CENTER OF THE PHILIPPINES
RADIOLOGY DEPARTMENT
Tel. Nos. 924-6101 loc. 256,339,279

X-RAY / ULTRASOUND REQUEST FORM

Write in capital letters. Check appropriate boxes.

OUTPATIENT ☑ OPD ☐ PAY IN PATIENT ☐ CHA ☐ PAY WARD ☐☐ ROOM _____

LAST NAME: SEPICO
FIRST NAME: VICTORIA
MIDDLE NAME:
AGE: 53 ~~MALE~~ ☐ ~~FEMALE~~ ☑ ~~BIRTHDAY~~: 3-23-1971
CIVIL STATUS: Married ~~RELIGION~~: Roman Catholic
ADDRESS: Bl L6 Celina Home IV Burgos, Rodriguez, Rizal
PROCEDURE: PET-CT scan w/ contrast if w/ (N) creatinine
DIAGNOSIS: BCA non small cell (R)
DATE: 01 Aug 2024 PHYSICIAN: [signature] Lopez
CONTACT NO: 09333119447 C.S.#
SIGNATURE: [signature] O.R.#
AMOUNT