PENAWAR
Bringing Quality Healthcare Nearer To You

POLIKLINIK PENAWAR
X-RAY REFERRAL FORM

PLEASE TICK (√) EITHER ONE OF OUR X-RAY CENTER BELOW:

☐ **POLIKLINIK PENAWAR KOTA TINGGI**
NO 30E, JALAN MAWAI,
81900 KOTA TINGGI, JOHOR.
TEL/FAKS : 07-8831944

☐ **POLIKLINIK PENAWAR SENAI**
NO 104 JALAN BINTANG,
81400 SENAI, JOHOR.
TEL/FAKS : 07-5995415

☐ **POLIKLINIK PENAWAR TMN UNIVERSITI**
NO 2, JALAN KEBUDAYAAN 5,
TAMAN UNIVERSITI,
81300 JOHOR BAHRU, JOHOR.
TEL/FAKS : 07-5214203

☐ **POLIKLINIK PENAWAR PANDAN**
NO 11, JALAN KESUM,
TAMAN ISTIMEWA PANDAN,
81100 JOHOR BAHRU, JOHOR.
TEL/FAKS : 07-3541281

☐ **POLIKLINIK PENAWAR MASAI**
NO.27, JALN MAWAR
81750 MASAI, JOHOR.
TEL/FAKS : 07-2528330

☐ **POLIKLINIK PENAWAR PONTIAN**
NO.894 JALAN BAKEK
82000 PONTIAN
TEL/FAKS : 07-6876608

FROM CLINIC / BRANCH

_____

PATIENT'S DETAILS

NAME : _____ NRIC / RS NO : _____

SEX : AGE : DATE : CHARGE TO : ☐ CLINIC ☐ PATIENT

X-RAY REQUESTED :

☐ Chest	☐ Humerus	☐ Femur
☐ Abdomen	☐ Elbow	☐ Knee
☐ Pelvis	☐ Radius Ulna	☐ Tibia Fibula
☐ Shoulder	☐ Wrist	☐ Ankle
☐ Others : _____	☐ Hand	☐ Foot

CLINICAL INFORMATION :

REFERRING DOCTOR :

REFERRING CLINIC :
(Clinic Stamp)

RADIOGRAPHER NAME :
(For internal use only)