

Radiology Request Form

(For suspected Dengue Hemorrhagic Fever)

Name: _____ W/o, D/o, S/o: _____ Age: _____

Sex: _____ Date: _____ Ward: _____ MRN No: _____

History:

Ultrasound:

Abdomen and pelvis to detect ascites

Chest to detect pleural effusion

X-Ray Chest:

Right lateral decubitus to detect minimal pleural effusion

PA view to assess pleural effusion

Report by Radiologist:

Name & Signature