UNIVERSITY OF ILORIN TEACHING HOSPITAL

Request for Endoscopic Examination

SURNAME MGBEHOTA	**FIRST NAME** PASCHAL		**AGE** 30yrs
SEX M	**WARD/CLINIC** MOPD.	**HOSPITAL NO.**	**DATE** 13/11/24
ADDRESS 18, obidegwu st Isa est Lagos		**OCCUPATION** Chemical Engineer	
REQUESTING DOCTOR'S NAME AND SIGNATURE Dr Fanus / 07069545430			
CONSULTANT Dr Bogunoye			
CLINICAL DETAILS / INITIAL DIAGNOSIS ? Bleeding PUD.			

TO BE COMPLETED BY A PHYSICIAN

EXAMINATION REQUEST

ARTHROSCOPY	**✓ OESOPHAGOGASTRODUODENOSCOPY**
BRONCHOSCOPY	**SIGMOIDOSCOPY**
COLONOSCOPY	**URETEROSCOPY**
CYSTOSCOPY	**UREA BREATH TEST (UBT)**
EUS	**OTHERS (SPECIFY)**
ERCP	**LARYNGOSCOPY**
	LAPARASCOPY

PREVIOUS OPERATIONS	**If yes - give detail**
BARIUM STUDIES	
ANY KNOWN ALLERGIES	