PR. No. 0380000480134

PERUMAL & PARTNERS

RADIOLOGISTS

Modalities: MRI, CT, X-ray, Ultrasound, Flouroscopy (Barium studies & VCU)
Dedicated Woman's Wellness Centre: Mammography, Breast Biopsy, BMD, Ultrasound

Ahmed Al-Kadi Private Hospital, 490 King Cetshwayo (Jan Smuts) Highway, Mayville, Durban info@perumalrad.co.za **031 492 6888**

TO BE COMPLETED BY REFFERING DOCTOR

PATIENT NAME: _____

D.O.B: ____/____/____ OUTPATIENT ☑ INPATIENT ☐ WARD_____

EXAMINATION REQUESTED (Specify)

- X- RAY ☑
- ULTRASOUND ☑
- CT SCAN ☑
- CT ANGIOGRAPHY ☐
- MRI SCAN ☐
- MAMMOGRAPHY ☐
- BONE DENSITY ☐
- FLUOROSCOPY ☐
- NUCLEAR MEDICINE ☐

(Please send previous imaging with patient)

CLINICAL INDICATION FOR IMAGING STUDY

REFERRING DR'S NAME: _____ DR'S PR. No.:_____

DATE: _____ SIGNATURE: _____

ICD 10 CODE

PATIENT TRANSPORT: AMBULANT ☐ WHEELCHAIR ☐ BED ☐

AFTER HOUR REQUESTS: URGENT ☐ MANE ☐ NEXT WORKING DAY ☐

FEMALE PREGNANT? Y ☐ N ☐ UNSURE ☐ LMP: ____/____/____

RISK FACTORS FOR CT or MRI CONTRAST

PREVIOUS REACTION TO CONTRAST MEDIA	Y	N	HYPERTENSIVE	Y	N
ALLERGIES	Y	N	PATIENT ON CHEMO	Y	N
DIABETIC	Y	N	RENAL IMPAIRMENT	Y	N

LATEST RENAL FUNCTION BLOOD RESULT:

DATE OF TEST: ...../...../.....

APPOINTMENT DATE: ___/___/____ APPOINTMENT TIME: _____

OFFICE USE:

MA ☐ PVT ☐ REQUEST RECEIVED BY: _____

DATE: ___/___/___ TIME: _____ Case ID:_____

NOTES: _____

PATIENT STICKER

PATIENT INFORMATION

Full Name:_____ ID No.:_____

Postal Address:_____ Residential Address:_____

_____ _____

_____ Code_____ _____ Code_____

Tel. Work:_____ Home:_____ Cell:_____

Dependant Code:_____ Relationship to member:_____ Email:_____

PATIENT CONSENT

I accept personal responsibility for payment for requested examination within 30 days - irrespective of any third party. I certify that my personal details above / on hospital sticker are correct. I give permission to divulge ICD 10 code and Radiology report to the requesting doctor / third party funder. I give access of my digital images on PACS/CD to my requesting doctor. I agree to have the requested examinatiion and hereby give consent for the injection or administration of any drug or contrast medium and use of any other item or procedure, which may be deemed necessary for the performance of my examination namely_____

Signed at:_____ **on this**_____ **day of**_____ **20**_____

Patient's / Member's / Guardian's Signature:_____

Witness (1):_____ Signature:_____ Witness (2):_____ Signature:_____

PERSON RESPONSIBLE FOR PAYMENT

Title_____ Initial_____ Surname_____ First Name_____ ID No_____

Medical Aid Name_____ Medical Aid Number_____

Plan Option_____ Dependant Code_____

Postal Address_____ Residential Address_____

_____Code_____ _____Code_____

Tel. Work_____ Cell_____ Residence_____

Member's e-mail_____ Employer_____

Work Address_____ Occupation_____ Employee No._____

_____Code_____ Fax_____ Contact Person_____

Relative/Friend Address_____ Code_____

FOR OFFICE USE

MA ☐

Patients Full Name_____

Date of Birth_____

Referring Doctor_____

Procedure Date_____

ICD 10 code_____

Cost of Scan_____

Authorisation Date_____

M.A. Authorisation No._____

Invoice / Receipt No._____

Tariff Code_____

Ref. Dr. Practice No._____

Hospital Authorisation No._____

Reference No._____

M.A. Authorised by_____

Length of stay updated Y ☐ N ☐

Invoice No._____

Account No._____

Medical Secretary Authorisation_____

PVT ☐

WCA ☐

IMM ☐

Medico Legal ☐

Cash ☐

Credit Card ☐

Amount_____

Discount_____

Inv./Rec. No._____

Account No._____

AUTHORISATION FOLLOW UP

Date	Time	Reception	Comments	Contact Person	Reference No.

RADIOGRAPHERS RECORDINGS (Exam / PACS / Other)

	Consumables

Patient Arrival Time:.....

Time Exam Started:.....

Radiographers Signature:..... Name:.....Date:.....Time Exam Completed:.....