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	**LATEST RENAL FUNCTION BLOOD RESULT:**
ALLERGIES	Y	N	PATIENT ON CHEMO	Y	N	**DATE OF TEST:**
DIABETIC	Y	N	RENAL IMPAIRMENT	Y	N	......../......../...........

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:..............................

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