

JACKPERSAD & PARTNERS INC

SPECIALIST DIAGNOSTIC RADIOLOGISTS

Practice No. 3804917

www.jackpersad.co.za

PATIENT INFORMATION

Patient Surname/ Title _____ Patient First Name _____
 Patient I.D.No. _____ Patient Date of Birth _____
 Patient Postal Address _____ Patient Residential Address _____
 _____ Code _____ Code _____
 Patient Tel. Work _____ Cell _____ Home _____
 Relation to Member _____ Dependent Code _____
 Female Patients: Are you pregnant? Yes No LMP _____
 W.C.A. Patients (only if applicable) Date of Injury _____ Claim No _____

TO BE COMPLETED BY REFERRING DOCTOR

CLINICAL DETAILS / MOTIVATION: _____ ICD 10 CODE _____

A. Examination request (Please send previous x-rays if available)

B. Suspected condition (clinical history) necessitating scan:

Referring Doctor's Name _____ Sign: _____
 Tel. Work _____ Cell _____ Fax _____
 E-mail Address _____ Pr. No. _____
 Appointment Date _____ Time: _____

CONSENT FOR PROCEDURE (only to be signed for certain examinations)

I 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 necessary for the performance of my examination which is

ALLERGIES

SIGNATURE _____ WITNESS _____

DATE: _____

MODALITIES

Venue	General X-ray	MRI	Mammo graphy	Ultra sound	CT	Barium Studies	Inter-ventional	IVP	Bone Density	Nuclear Medicine	Pet/ CT
Ascot Park Hospital	✓										
Chatsmed Garden Hospital	✓	✓	✓	✓	✓	✓		✓			
City Hospital	✓		✓	✓	✓	✓		✓			
Durdoc Hospital	✓			✓							
eThekwini Hospital & Heart Centre	✓	✓	✓	✓	✓	✓	✓	✓			
Hillcrest Private Hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Howick Private Hospital	✓			✓							
Isipingo Hospital	✓			✓	✓	✓		✓			
Midlands Med Centre	✓			✓	✓	✓		✓			
Mt Edgecombe Hospital	✓		✓	✓	✓	✓		✓			
PMB Mediclinic Hospital	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Sydenham Med Centre	✓			✓							
Victoria Hospital	✓		✓	✓	✓	✓		✓	✓		
Westridge Med Centre	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓

ADMIN. - ACCOUNTS

3rd Floor, Maxwell Centre,
 71/73 Ismail C Meer Street, (Lorne St)
 DURBAN 4001
 ☎ 031 365 2100 Fax: 031 365 2199

ASCOT PARK HOSPITAL

Suite 106, 1st Floor, 3 Ascot Street
 GREYVILLE 4001
 ☎ 031 3652135
 Fax: 086 616 2377 a/h 031 374 8000

CHATSMED GARDEN HOSPITAL

80 Woodhurst Drive, Woodhurst,
 CHATSWORTH 4092
 ☎ 031 402 9280
 Fax: 031 402 9285 a/h 031 459 8000

CITY HOSPITAL

83 Ismail C Meer Street (Lorne St.)
 DURBAN 4001
 ☎ 031 365 2110 / 1 / 2 / 3
 Fax: 031 365 2198 a/h 031 314 3000

DURDOC CENTRE

1404 Durdoc Centre,
 460 Anton Lembede Street,
 DURBAN 4001
 ☎ 031 305 9559
 Fax: 031 305 9559

eTHEKWINI HOSPITAL & HEART CENTRE

11 Riverhorse Road,
 Riverhorse Valley Bus. Estate,
 Nandi Drive, DURBAN 4071
 ☎ 031 569 6645/6
 Fax: 031 569 6647
 a/h: 031 581 2400

HILLCREST PRIVATE HOSP.

Ground Floor, Radiology Department
 471 Kassier Road
 ASSAGAY 3610
 ☎ 031 768 1800 Fax: 031 768 1790
 A/h 031 768 8000

HOWICK PRIVATE HOSPITAL

107 Main Street, HOWICK 3290
 ☎ 033 330 5962
 Fax: 086 6169 194
 a/h 033 330 2456

ISIPINGO HOSPITAL

162 Old Main Road,
 ISIPINGO RAIL 4110
 ☎ 031 910 7220
 Fax: 031 902 8468 a/h 031 913 7000

MIDLANDS MED. CENTRE

162 / 6 Masukwana Street
 PIETERMARITZBURG 3201
 ☎ 033 392 4780 Fax: 033 392 4785
 a/h 033 341 5000

MT EDGECOMBE HOSP.

602 Redberry Drive,
 PHOENIX 4068
 ☎ 031 502 9500
 Fax: 031 502 9505 a/h 031 537 4000

MEDICLINIC HOSPITAL (PMB)

90 Payne Street,
 PIETERMARITZBURG 3201
 ☎ 033 392 4720 Fax: 033 392 4725
 a/h 033 845 3700

SYDENHAM MED. CENTRE

11 Bazley Ave. Sydenham
 DURBAN 4091
 ☎ 031 2048040 Fax: 031 2048045

VICTORIA HOSPITAL

35 High Street, TONGAAT 4400,
 ☎ 032 438 3200
 Fax: 032 438 3205
 a/h 032 944 5061

WESTRIDGE MED. CENTRE

95 King Cetshwayo, Westridge
 DURBAN 4001
 ☎ 031 273 1050
 Fax: 031 261 6217

FOR INTERNAL USE (Telephonic Authorisation)

Invoice No _____ Patient ID: _____ Case ID _____ Proc ID _____
 Date of Procedure _____ Tariff Code _____ Authorisation No _____
 Authorised by _____ Receptionist _____
 Comments _____

PERSON RESPONSIBLE FOR PAYMENT

Title _____ Initial _____ Surname _____ First Name _____ ID No _____
 Medical Aid Name _____ No. _____ Plan Option _____
 Postal Address _____ Residential Address _____

 _____ Code _____ Code _____
 Tel. Work _____ Cell _____ Home _____
 Employer _____
 Work Address _____ Occupation _____
 _____ Employee No _____
 _____ Fax No _____
 Code _____ Contact Person _____
 Relative/Friend _____ Relative Tel _____
 Relative/Friend Address _____ Code _____

I certify that the above details are correct. I further accept on behalf of the member/myself ultimate personal responsibility for the payment in full of any amount incurred in relation to radiological procedures done as a result of the above request.
 This is irrespective of any third party such as medical aid/any other medical insurance. I do hereby acknowledge that I am truly and lawfully indebted to Jackpersad & Partners Inc. in the sum of _____
 R_____. I hereby bind myself to pay the full amount of the said capital by not later that Date of payment _____

I acknowledge that if this amount is not settled on the due date, the management of Jackpersad & Partners Inc. shall have irrevocable right to recover the said debt from me and I further agree to pay attorney/clients cost thereof. Interest will be charged should payment not be received on the due date. I will inform Jackpersad & Partners Inc. timeously should any of the above details change. I also acknowledge the above fees do not include any of the other doctors, laboratories or hospital costs.

I hereby give permission for my ICD10 code to be revealed to my Medical Aid Do Don't

Signed at _____ on this day of _____ 20_____.
 Debtor's Signature _____ Witness 1 _____
 _____ Witness 2 _____

FOR INTERNAL USE

EXAMINATIONS (+ EXTRA VIEWS OR ADDITIONS)		CONTRAST			OTHER ITEMS		
	Details all usual views + any extra study or extra views e.g. obliques	NAME	PACK	NO	NAME	SIZE/VOL	NO
1					Syringe		
2					Syringe		
3					Needle/Swab		
4					Gloves		
5					Sterile pack		

Theatre Att.....hrs Screeningmins

What else did you use..... A.H.....

Charge as: Med Aid PVT IMM WCA Discount.....

MEDICO – LEGAL

Doc.....

Rad.....

Check List

- 1 Completed Request Form
- 2 Medical Aid Card
- 3 ID Document
- 4 Correct Icd 10 Codes
- 5 Procedure Codes
- 6 Signature of Patient/Member
- 7 Member informed about billing policies
- 8 Invoice Printed

WCA Check List

- 1. Completed Request Form
- 2. Completed & Signed WCL2
- 3. Completed WCL 4
- 4. ID Document
- 5. Travel Questionnaire
- 6. Motivation Letter