



JACKPERSAD & PARTNERS INC.

SPECIALIST DIAGNOSTIC RADIOLOGISTS

Practice No. 3804917

info@jrp.co.za

www.jackpersad.co.za

ASCOT PARK HOSPITAL

3 Ascot Street
GREYVILLE
☎ 031 365 2135
a/h: 031 314 3000

LIFE CHATSMED GARDEN HOSP.

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

CITY HOSPITAL

83 Ismail C Meer Street
DURBAN
☎ 031 309 8465
a/h: 031 314 3000

DAYMED PRIVATE HOSP

595 Chota Motala Rd.
Raisethorpe
PIETERMARITZBURG
☎ 087 501 0043
a/h 033 387 1100

DURDOC HOSPITAL

460 Anton Lembede Street,
DURBAN
☎ 031 305 9559
a/h: 031 314 3000

EDEN GARDENS

PRIVATE HOSPITAL

Archie Gumede Rd,
PIETERMARITZBURG
☎ 087 501 0042
A/H 033 815 4600

LENMED & THE KWINI HOSPITAL

& HEART CENTRE
11 Riverhorse Road,
Nandi Drive, DURBAN
☎ 031 569 6645 / 6
a/h: 031 581 2400

BUSAMED HILLCREST

PRIVATE HOSPITAL

471 Kassier Road, ASSAGAY
☎ 031 768 1800
a/h: 031 768 8000

ISIPINGO HOSPITAL

162 Phila Ndwandwe Road
ISIPINGO RAIL
☎ 031 910 7220
a/h: 031 913 7000

LENMED SHIFA

PRIVATE HOSPITAL

482 Randles Road, OVERPORT
☎ 087 501 0041
a/h: 031 240 5000

LIFE MT.EDGEcombe HOSP

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

MEDICLINIC HOWICK

HOSPITAL

107 Main Street, HOWICK
☎ 033 330 5962
a/h: 033 330 2456

MIDLANDS MED. CENTRE

162/6 Masukwana Street
PIETERMARITZBURG
☎ 033 392 4780
a/h: 033 341 0000

MEDICLINIC PMB

HOSPITAL

90 Payne St.
PIETERMARITZBURG
☎ 033 392 4720
a/h: 033 845 3700

MEDICLINIC VICTORIA HOSP.

35 High Street, TONGAAT
☎ 032 438 3200
a/h: 032 945 8200

WESTRIDGE MED. CENTRE

95 King Celschwayo Highway,
WESTRIDGE, DURBAN
☎ 031 273 1050

THIS SECTION MUST BE COMPLETED BY REQUESTING MEDICAL PRACTITIONER

PATIENT NAME _____ D.O.B. ____ / ____ / ____

MEDICAL AID WCA PRIVATE ICD 10 CODE _____

DATE OF INJURY ____ / ____ / ____ EVENT NO. _____

CLINICAL INFORMATION / DIAGNOSIS _____

EXAMINATION/S REQUESTED _____

PRACTITIONER'S NAME _____ PRACTITIONER'S SIGNATURE _____

PRACTICE NO. _____ TELEPHONE: _____ EMAIL _____

NURSE / RECEPTIONIST NAME _____ SIGNATURE _____

Tel. Work _____ Home _____

Dependent Code _____

Cell _____

Relationship to member _____ Female: pregnant? YES NO UNSURE

E-Mail _____ LAST MENSTRUAL PERIOD _____

RADIOLOGIST CONSULT / RECOMMENDATION

SIGNATURE _____ DATE _____

THIS SECTION MUST BE COMPLETED BY THE PATIENT IN FULL

1. I have been examined by the above requesting Practitioner Yes No

2. I agree to have the requested examination..... Yes No

3. I accept personal responsibility for payment for requested examination

within 30 days - irrespective of any third party..... Yes No

4. I certify that my personal details above / on hospital sticker are correct..... Yes No

5. I give permission to divulge ICD 10 code Radiology report to the requesting...

Practitioner / Third Party funder..... Yes No

6 I give access of my digital images on PACS/CD to my requesting Practitioner..... Yes No

7. I accept that in the event of non payment in 30 days, interest & Debt collection charges may be charged. Yes No

Signed at _____ on this _____ day of _____ 20 _____

Patient's / Members's/Guardian Signature _____ Witness 1 _____ Witness _____

APPOINTMENT DATE _____ TIME _____ ARRIVAL DATE _____ TIME _____

Patient I D _____ Case I D _____ Proc I D _____

CONSENT FOR PROCEDURE

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 deemed necessary for the performance of my examination namely _____

ALLERGIES _____

SIGNATURE _____ WITNESS _____ DATE ____ / ____ / ____

PERSON RESPONSIBLE FOR PAYMENT

Title _____ Initial _____ Surname _____ First Name _____ ID No. _____
Medical Aid Name _____ Medical Aid Number _____
Plan Option _____ Dependent Code _____
Postal Address _____ Residential Address _____
_____ Code _____ Code _____
Telephone Work _____ Cell _____ Residence _____
Member's e-mail _____ Employer _____
Work Address _____ Occupation _____ Employee No _____
_____ Code _____ Fax _____ Contact Person _____
Relative / Friends Address _____ Code _____

FOR OFFICE USE: MEDICAL AID AUTHORISATION

Patients full name _____ Tariff Code _____
Date of Birth _____ Practice No _____
Referring Doctor _____ Hospital Authorisation No _____
Procedure Date _____ Reference No. _____
ICD 10 code _____ M.A Authorised by _____
Cost of scan _____ Length of stay updated Yes No
Authorisation date _____ Invoice Number _____
M.A. Authorisation No _____ Medical Secretary: Authorisation _____

AUTHORISATION FOLLOW UP

Date	Time	Reception	Comments	Contact Person	Reference No

TO BE COMPLETED BY RADIOGRAPHER

EXAMINATION

CONSUMABLES

Theatre : Time In _____ Time out _____ Screening _____ minutes Dose _____

Images : Prints CD's Film Received by _____ Signature _____

DOC
RAD.....