ASCOT PARK HOSPITAL
3 Ascot St, **GREYVILLE**
☎ 031 365 2135
a/h: 031 314 3000

BALLITO
Odyssey Medical Precinct
1 Simbithi Drive, **BALLITO**
☎ 087 077 5952

CAPITAL HAEMATOLOGY HOSP.
95 King Cetshwayo Highway
Westridge, **DURBAN**
☎ 087 077 5974

LIFE CHATSMED GARDEN HOSP.
80 Woodhurst Drive, Woodhurst
CHATSWORTH
☎ 031 402 9280
a/h: 031 459 8000

CITY HOSPITAL
83 Ismail C Meer St. **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 Road
PIETERMARITZBURG
☎ 087 501 0042
a/h: 033 815 4600

LENMED eTHEKWINI 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

LENMED HOWICK PRIVATE 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 5000

MEDICLINIC PMB. HOSPITAL
90 Payne St. **P.M BURG**
☎ 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 Cetshwayo Highway,
WESTRIDGE, **DURBAN**
☎ 031 273 1050

INTERCARE WOODBURN
Woodburn Square,
15 Woodhouse Rd, Scottsville
PIETERMARITZBURG
☎ 087 501 0047

JACKPERSAD & PARTNERS INC.

SPECIALIST DIAGNOSTIC RADIOLOGISTS

Practice No. 3804917 info@jrp.co.za www.jackpersad.co.za

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_____

PATIENT'S DETAILS

Full Name _____

ID No. _____

Postal Address _____

_____ Code_____

Residential Address _____

_____

_____ Code_____

Tel. Work _____ Home_____

Dependent Code _____

Cell _____

Relationship to member _____

E-Mail _____

PLACE STICKER HERE

Female: pregnant? YES ☐ **NO** ☐ **UNSURE** ☐

LAST MENSTRUAL PERIOD_____

RADIOLOGIST CONSULT / RECOMMENDATION

_____

_____

SIGNATURE_____ DATE_____

THIS SECTION MUST BE COMPLETED BY THE PATIENT IN FULL

	Yes	No
1. I have been examined by the above requesting Practitioner	☐	☐
2. I agree to have the requested examination	☐	☐
3. I accept personal responsibility for payment for requested examination within 30 days - irrespective of any third party	☐	☐
4. I certify that my personal details above / on hospital sticker are correct	☐	☐
5. I give permission to divulge ICD 10 code Radiology report to the requesting... Practitioner / Third Party funder	☐	☐
6 I give access of my digital images on PACS/CD to my requesting Practitioner	☐	☐
7. I accept that in the event of non payment in 30 days,interest & Debt collection charges may be charged.	☐	☐

Signed at_____ **on this**_____ **day of** _____ **20**_____

Patient's/ Members's/Guardian Signature_____ **Witness 1**_____ **Witness 2** _____

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_____ Dependant 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 _____Contact No._____

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.....