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a/h: 032 945 8200

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JACKPERSAD & PARTNERS INC.

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Practice No. 3804917 www.jackpersad.co.za

THIS SECTION MUST BE COMPLETED BY REQUESTING MEDICAL PRACTICNER

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** _____

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_____ Depedent 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.....