BERGMAN, ROSS & PARTNERS
BR&P
RADIOLOGISTS

N1 CITY HOSPITAL: TEL 021 595 1370 (ALL HOURS) | **KUILS RIVER HOSPITAL:** TEL 021 276 4177
NETCARE ONCOLOGY & INTERVENTIONAL CENTRE: TEL 021 595 1370 | **SEA POINT:** TEL 021 110 5777
INTERCARE BLAAUWBERG: TEL 021 276 1068 | INTERCARE TYGERVALLEY: TEL 021 276 1069
INTERCARE PAROW: 021 276 0170

PR NO 3803465

DR. J.W. BERGMAN | DR. J. ROSS | DR. B. COTTON | DR. J. BEKKER | DR. J. BASSON
Dr. Y. VADACHIA | DR. M.A. HAYES | DR. A.D. BRANDT | DR. A. SABAN | DR. S. FAYKER

Request for X-Ray Examination

Radiographer - N1 City Cell No.: 082 774 6268 **Radiographer - Kuils River Cell No.:** 072 508 9301

Date:	Date of Birth:
Name:	ICD 10 Code:
Medical Aid.	Medical Aid No.
Female Patients Are you pregnant? YES NO	Authorisation No:
	Dependent Code:
Allergies specify:	

Examination - Please tick the following:

X-RAY | ULTRASOUND | SCREENING | BMD | CT SCAN | MRI | MAMMOGRAM

Type of Examination

Clinical History

FOR MRI PATIENTS:
Do you have any foreign material in your body:

- ☐ Cardiac Pacemaker
- ☐ Intracranial Aneurysm Clips
- ☐ Neurostimulator
- ☐ Cochlear Implant

Other _____

RENAL FUNCTION IF CONTRAST MR/CT AND RENAL RISK FACTORS
Age >60 years
Significant history of renal disease including:

- Dialysis
- Hypertension requiring medical therapy
- Renal transplant
- Diabetes mellitus
- Single kidney
- Metformin or metformin-containing medication
- Renal cancer or surgery

Ref. Doctor: _____ Practice No: _____

Tel No: _____

Signature: _____ Fax No: _____

DECLARATION

I hereby give consent to the injection or administration of any Radiology contrast media or medication which may be necessary for the performance of my radiology examination. Notwithstanding any Medical Aid Society or other organisation's undertaking, I acknowledge personal responsibility for the payment of the account within 30 days.
As a Private Patient without a medical aid I agree to pay for the procedure/s on the day.

I hereby give consent to disclose the diagnostic codes (regarding my illness) to either my medical aid or government institution, as required. YES NO

PATIENT NUMBER BARCODE

Patient Signature: _____

Patient Name: _____

Date: _____

DOCUMENT TYPE BARCODE