



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 1070

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 | Please send completed form to bookings@bergmanross.co.za

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Authorisation No:						
Allergies specify:	Dependent Code:						

PLEASE INDICATE WHICH BRANCH: N1 CITY KUILS RIVER SEA POINT TYGERVALLEY PARKLANDS PAROW

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: _____
 Signature: _____ Tel No: _____
 Fax No: _____

INDEMNIFICATION AND CONSENT

<p>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. <input type="checkbox"/></p> <p>Notwithstanding any Medical Aid Society or other organisation's undertaking, I acknowledge personal responsibility for the payment of the account within 30 days. <input type="checkbox"/></p> <p>As a Private Patient and Patients without a valid medical aid, I agree to pay for the procedure/examination on the day. <input type="checkbox"/></p> <p>I authorise and give consent to Bergman Ross & Partners to release my medical reports, diagnostic images and referral letters for the purpose of mediating my radiology account with my medical aid as well as my referring doctor and other specialists. <input type="checkbox"/></p>	<p>I hereby give consent to disclose the diagnostic codes (regarding my illness) to either my medical aid or government institution for statistical purposes, as well as 3rd parties as per conditions of the POPI (PAIA) Act of 2013. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Patient Signature: _____</p> <p>Patient Name: _____</p> <p>Date: _____</p>
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