N1 CITY HOSPITAL: TEL 021 595 1370 (ALL HOURS) | **KUILS RIVER HOSPITAL**: TEL 021 276 4177 (ALL HOURS)
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? ☐ YES ☐ NO	Authorisation No: Dependent Code:
Allergies specify:	

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

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

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

Other ______

Clinical History

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: ______

INDEMNIFICATION AND CONSENT

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 and Patients without a valid medical aid, I agree to pay for the procedure/examination on the day. ☐

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. ☐

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. YES NO

Patient Signature: ______

Patient Name: ______

Date: ______