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

PR NO 3803465

DR J.W. BERGMAN | DR J.L. ROSS | DR B.A. COTTON | DR J.V. BEKKER | DR J.C. 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

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
- ☐ Insulin Pump 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

REFERRING DOCTOR: ____________________ TEL NO.: ____________________

SIGNATURE: ____________________ EMAIL: ____________________

PRACTICE NO.: ____________________ RESULTS.: EMAIL ____________________

INDEMNIFICATION AND CONSENT

I confirm that the information supplied is true and correct. I agree and understand that:

- The member will carry all costs/ penalties incurred as a result of failed pre-authorisation. Should legal steps be instituted for the collection of outstanding funds, I shall be liable for costs of an attorney/ client scale.
- 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 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 mediation my adiology account with my medical aid, as well as government institutions for statistical purposes.
- All procedures performed at this facility will be online and available to a restricted community of clinicians. I hereby give consent for my radiology images and reports to be released to all 3rd parties forming part of my circle of healthcare as per conditions of the POP (PAIA) Act of 2013.

Patient Signature: ____________________ **Patient Name**: ____________________ **Date**: ____________________