Richardson Udarajh
& PARTNERS INC. | DIAGNOSTIC RADIOLOGISTS

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PR 0109126

REQUEST FOR DIAGNOSTIC RADIOLOGY

Patient Name: ..... Date: .....

Referring Doctor: ..... Ward/Section: .....

Medical Aid & Plan:..... Medical Aid Number: .....

Is the patient pregnant? Y | Iodine allergy? Y | Is the patient claustrophobic? Y | For CT & MRI: Please advise patient's weight kg

EXAMINATION TYPE	✓	REGION(S) REQUIRED FOR EXAMINATION / SPECIAL REQUESTS
PLAIN X-RAYS		.....
BARIUM ETC		.....
ULTRASOUND		.....
DOPPLER		.....
MAMMOGRAM		.....
BONE DENSITY		.....
CT		.....
MRI		.....

CLINICAL DETAILS / REASON FOR EXAMINATION / MOTIVATION

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..... ICD-10 CODE(S):

DOCTOR'S NAME: SIGNATURE:

IMPORTANT NOTICE:

1. All patients must produce their ID document
2. Medical aid patients MUST produce their medical aid card
3. Patients without a medical aid card will be required to pay cash
4. WCA Patients must bring their WCA form or claim number

FOR OFFICE USE:

MEMBER NO: ..... SCAN DATE: .....

CONTACT NO:..... SCAN TIME: .....