EUGENE MARAIS RADIOLOGY INC | INGELYF

EUGENE MARAIS HOSPITAL | C/O 5TH AVENUE & FRED NICHOLSON STREET, LES MARAIS, 0084

TEL | 012 335 2411 **EMAIL** | info@emradiology.co.za

PR NR. 3804259 *REG NO. 1996/012432/21*

PATIENT
PASIËNT _____

MEDICAL AID
MEDIESE FONDS _____

MED AID NUMBER
MED FONDS NOMMER _____

FIRST VISIT
EERSTE BESOEK YES NO

REFERRING DOCTOR
VERWYSENDE DOKTER _____

CLINICAL PARTICULARS
KLINIESE BESONDERHEDE _____

_____

ICD 10 CODES
ICD 10 KODES

COPY TO
AFSKRIF AAN _____

ALLERGIC TO IODINE
ALLERGIES VIR JODIUM YES NO

PREGNANT
SWANGER YES NO

KIDNEY FAILURE
NIERVERSAKING YES NO

CREATININE
KREATINIEN

UREA
UREUM

eGFR
bGFS

EXAMINATION REQUIRED | ONDERSOEK VERSOEK		
1. X-RAYS X-STRALE		
2. ULTRASOUND SONAR		
3. CT RT		
4. MR PR NO: 3805743		
5. MAMMOGRAPHY MAMMOGRAFIE		
6. BONE DENSITY BEENDIGTHEID		

MAGTIGINGSNR. INDIEN VAN TOEPASSING
AUTHORIZATION NO. IF APPLICABLE _____

HANDTEKENING | SIGNATURE _____ DATUM | DATE _____

PATIENT INFORMATION | PATIËNT BESONDERHEDE

TO BE COMPLETED BY PATIENT (PREFERABLY BEFORE RADIOLOGY EXAMINATION)
OM DEUR PATIËNT VOLTOOI TE WORD (VERKIESLIK VOOR DIE RADIOLOGIESE ONDERSOEK)

PATIENT SURNAME
PASIËNT SE VAN _____

TITLE
TITEL
DR | MR. MNR. | MRS. MEV. | MISS. MEJ. | ____

FULL NAMES
VOLLE NAME _____

SEX
GESLAG
M | F

BIRTH DATE
GEBOORTEDATUM
D D M M Y Y

ID NO
ID NO

AGE
OUDERDOM

MEDICAL AID NAME
MEDIESE FONDS NAAM _____

PLAN
PLAN _____

MEDICAL AID NO
MEDIESE FONDS NR _____

DEPENDANT CODE
AFHANKLIKE NR _____

WCA
BAD _____

DATE OF INJURY
DATUM VAN BESERING _____

CLAIM NO
EISNOMMER _____

E-MAIL ADDRESS
E-POS ADRES _____

CELL NO
SEL NR _____

THIRD PARTY CLAIM
DERDE PARTY EIS ☐

INSURANCE CLAIM
VERSEKERINGS EIS ☐

REF NO
VERWYSINGS NR _____

PERSON RESPONSIBLE FOR PAYMENT | PERSOON VERANTWOORDELIK VIR BETALING

SURNAME
VAN _____

INITIALS
VOORLETTERS _____

TITLE
TITEL
DR | MR. MNR. | MRS. MEV. | MISS. MEJ. | ____

MEMBER'S ID NO
LID SE ID NR

All patients must produce an ID document and medical aid card. Private patients and patient without a medical aid card, must pay for services at the time of service.

Alle pasiënte moet 'n ID dokument en mediese fonds kaart toon. Privaat pasiënte en pasiënte sonder 'n mediese fonds kaart, betaal onmiddelik vir dienste wanneer dit gelewer word.

POSTAL ADDRESS
POSADRES _____

RESIDENTIAL ADDRESS
WOONADRES _____

CODE
KODE _____

CODE
KODE _____

HOME TEL NO
HUIS TEL NR _____

E-MAIL ADDRESS
E-POS ADRES _____

CELL NO
SEL NR _____

EMPLOYER NAME
WERKGEWER NAAM _____

TEL NO
TEL NR _____

EXT
UITBR _____

OCCUPATION
BEROEP _____

EMPLOYER ADDRESS
WERKGEWER ADRES _____

CODE
KODE _____

NAME AND ADDRESS OF FAMILY MEMBER OR FRIEND (not living with member)
NAAM VAN FAMILIELID OF VRIEND (wat nie by lid inwoon nie) _____

CODE
KODE _____

RELATION
VERWANTSKAP _____

TEL NO
TEL NR _____

E-MAIL ADDRESS
E-POS ADRES _____

EMR
EUGENE MARAIS RADIOLOGY
INC | INGELYF

EUGENE MARAIS HOSPITAL | C/O 5TH AVENUE &
FRED NICHOLSON STREET, LES MARAIS, 0084

TEL | 012 335 2411 **EMAIL** | info@emradiology.co.za
PR NR. 3804259 *REG NO. 1996/012432/21*

PATIENT STICKER

DATE REQUESTED _____

TIME REQUESTED _____

PRIORITY _____

HISTORY _____

REFERRING DOCTOR _____

ICD 10 CODES | | | | |

☐ WALKING ☐ WHEEL CHAIR ☐ BED ☐ PORTABLE ☐ ISOLATION INFECTION CONTROL REQUIRED

EXAMINATION REQUIRED		
1. X-RAYS		
2. ULTRASOUND		
3. CT		
4. MR PR NO: 3805743		
5. MAMMOGRAPHY		
6. BONE DENSITY		

UREA

CREATININE

eGFR

PATIENT ALLERGIC TO IODINE YES NO

PATIENT PREGNANT YES NO

AUTHORIZATION NO. IF APPLICABLE _____

HANDTEKENING | SIGNATURE _____ DATUM | DATE _____