

Imaging Request Form

MRI, CT, Mammogram, EKG, X-ray, Ultrasound
Scheduling Tel: +231 88 160 3000 / +231 77 660 3000
Email: imagingervices@jahmalemedical.org
Reg. No. 052115698

Ref. Number

Barcode

<p>Patient Details:</p> <p>Last Name:</p> <p>First Name:</p> <p>Date of Birth: <u>DD / MM / YYYY</u> Age: _____ Gender: M <input type="checkbox"/> F <input type="checkbox"/></p> <p>ID Number:</p> <p>Address:</p> <p>Mobile Number:</p> <p>Email:</p>	<p>Payment Details: Priority: _____</p> <p>By Patient <input type="checkbox"/> Monthly Payment <input type="checkbox"/></p> <p>Person(s) Responsible For Payment:</p> <p>Patient's Insurance Company:</p> <p>Membership Number:</p> <p>Pre-Authorization Number (If Known):</p> <p>Please note: <i>Uninsured patients and patients without pre-authorization are required to pay on the day of their appointment.</i></p>
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<p>Referral Information:</p> <p><input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> X-RAY <input type="checkbox"/> ULTRASOUND <input type="checkbox"/> MAMMOGRAM <input type="checkbox"/> EKG</p> <p>Area to be imaged:</p> <p>Creatinine level: Date of Test:</p>	<p>Relevant Medical History: <i>Details (Including any surgery and current medication)</i></p> <p>.....</p> <p>.....</p> <p>Please include copies of any recent X-ray or scan reports</p>
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<p>Safety Check:</p> <p>Could the patient be pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the patient breast feeding? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the patient a high infection risk? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please specify</p> <p>Is the patient diabetic Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is the diabetes controlled by: Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Tablet <input type="checkbox"/></p> <p>Is the patient on Metformin? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Does the patient have any allergies Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please specify:</p> <p>Patient arrival: Stretcher <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walking <input type="checkbox"/></p>	<p>To be completed for all MRI examinations MRI Contraindications – does the patient have:</p> <p>A pacemaker? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>A cerebral aneurysm clip? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Cochlear implants? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Neurostimulators? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Programmable hydrocephalus shunt? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Metallic foreign body in eye? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Other metallic implants? Yes <input type="checkbox"/> No <input type="checkbox"/></p>
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<p>Referring Clinician's Details (To be signed by the Referring Clinician):</p> <p>Name:</p> <p>Signature: Date:</p>		<p>Address:</p> <p>Tel: Fax:</p> <p>Email:</p>
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<p><i>I, certify that the above information is correct and give specific consent for the test(s) to be done. I have received pre-test counseling. I, undertake to pay outstanding monies not covered by my medical insurance.</i></p> <p>Patient's Signature:</p>	<p>Amount Billed:</p>	<p>Amount Paid:</p>	<p>Balance:</p>
	<p>Received By:</p>		
	<p>Form Filled By:</p>	<p>Reg. By:</p>	

