

A. 8. Tolbert Road, ELWA Junction, Paynesville, Liberia

+231 881 60 30 00 / +231 776 60 30 00

www.jahmalemedical.org

info@jahmalemedical.org

Imaging Request Form

MRI, CT, Mammogram, EKG, X-ray, Ultrasound Scheduling Tel: +231 88 160 3000 / +231 77 660 3000

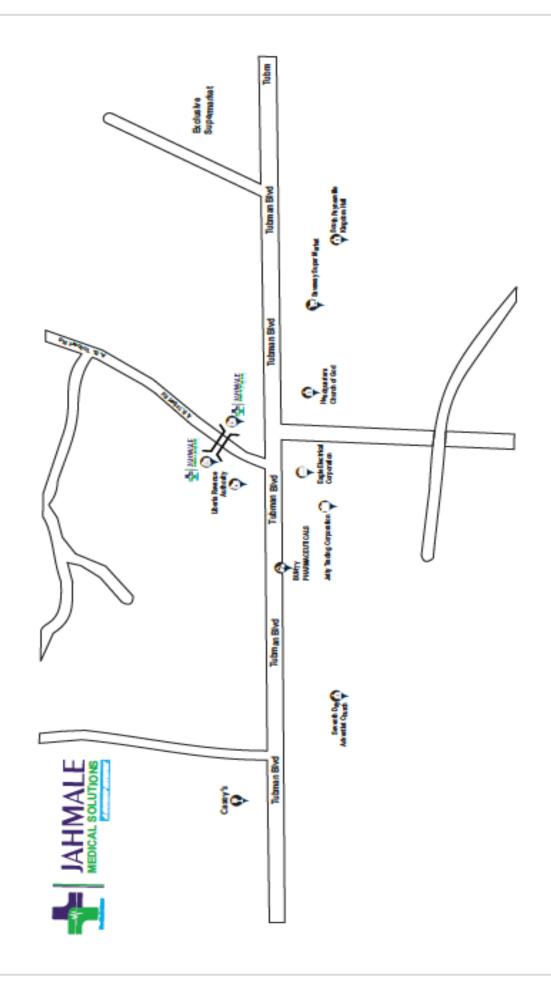
Email: imagingservices@jahmalemedical.org

Reg. No. 052115698

Ref. Number	Barcode

Patient Details:	Payment Details:	Priority:	
Last Name:	By Patient Monthly Payment		
First Name:	Person(s) Responsible For Payment:		
Date of Birth:DD / MM / YYYY_ Age: Gender: M F			
ID Number:	Patient's Insurance Company:		
Address:	Membership Number:		
	Pre-Authorization Number (If Known):		
Mobile Number:	Please note: Uninsured patients and patients without pre-authorization are required to pay on the day of their appointment.		
Email:			
Referral Information:	Relevant Medical History:		
MRI CT X-RAY ULTRASOUND MAMMOGRAM	Details (Including any surgery of EKG	and current medication)	
Area to be imaged:			
Creatinine level: Date of Test:	Please include copies of any re	ecent X-ray or scan reports	
Safety Check:			
Could the patient be pregnant? Yes No No	To be completed for all MRI examinations MRI Contraindications – does the patient have:		
Is the patient breast feeding?	wiki Contraindications – does the	patient nave:	
Is the patient a high infection risk? Yes \Box No \Box	A pacemaker?	Yes No	
If yes, please specify	A cerebral aneurysm clip?	Yes □ No □	
Is the patient diabetic Yes \square No \square	Cochlear implants?	Yes □ No □	
Is the diabetes controlled by: Diet Insulin Tablet	Cocineal implants:	ies u nou	
Is the patient on Metformin?	Neurostimulators?	Yes □ No □	
Does the patient have any allergies Yes No No	Programmable hydrocephalus shunt?	Yes □ No □	
If yes, please specify:	Metallic foreign body in eye?	Yes □ No □	
Patient arrival: Stretcher Wheelchair Walking	Other metallic implants?	Yes □ No □	
Referring Clinician's Details (To be signed by the Referring Clinician):	Address:		
No. 11	Tel: Fax:		
Name:	Tel FdX.		
Signature: Date:	Email:		
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.	g. Amount Billed: Amount Paid:	Balance:	
insurance.	Received By:		
Patient's Signature:	Form Filled By: Reg. B	y:	

IMPLEMENTED 16TH FEBRUARY 2021 EDITION 8



IMPLEMENTED 16TH FEBRUARY 2021 EDITION 8