UMHLANGA
MOLECULAR IMAGING AND THERAPY
Nuclear Medicine Centre of Excellence

Pr No: 0542660 **Dr Masha Maharaj**

PATIENT'S INFORMATIONS

Title ____ Initial___ Patient's Surname_____

Last Name_____

Gender _____ Date of Birth_____ I.D_____

Relation to Member_____ Dependents No _____

Female Patients:

Are you pregnant? Yes/ No LMP_____

PERSON RESPONSIBLE FOR PAYMENT

Title ___ Initial____ Surname _____ First Name_____

ID no _____ Med. Aid Name_____ No _____

Postal Address_____ Code_____

Res. Address_____ Code_____

Tel. (Home) _____ Cell _____ E-mail _____

Employer: (Company Name) _____

Work Address_____

Tel (Work):_____ Fax_____ Occupation_____

Relative/Friend (Not living with Patient) _____ Tel_____

Address of Relative/Friend_____ Code _____

TO BE COMPLETED BY THE REFERING DOCTOR

Please fill in ICD- 10 CODE……

CLINICAL DETAILS/MOTIVATION

A. Examination request (Please send previous x-rays/ CT/MRI on CD if available)

_____

B. Suspected condition (clinical history) necessiting scan:

_____

C. Investigation completed to date for this condition:

_____

Doctor's Name_____ Sign:_____

Tel_____ E-mail Address_____

Pr. No_____ Appointment date/Time_____

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