JAHMALE MEDICAL SOLUTIONS

X-RAY

X-RAY RADIOLOGY REQUEST FORM – HEAD OFFICE (ELWA JUNCTION)

Doc Number: RF-JMS-MRQF-005	**Revision:** 002
Approved by: Technical Administrator **Date:** April 2023	**Issued by:** QA Department **Date:** April 2023
Supersedes: RF-JMS-MRQF-005 (001)	**Author:** QA Department
Date Implemented: April 2023	

Radiological Services/Examinations include:

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:

Last Name: .....

First Name: .....

Date of Birth: DD / MM / YYYY Age:_____ Gender: M ☐ F ☐

ID Number: .....

Address: .....

Mobile Number: .....

Email: .....

Payment Details: **Priority: _____**

By Patient ☐ Monthly Payment ☐

Person(s) Responsible For Payment:

Patient's Insurance Company: .....

Membership Number: .....

Pre-Authorization Number (If Known): .....

Please note: *Uninsured patients and patients without pre-authorization are required to pay on the day of their appointment.*

Referral Information:

☐ **XRAY**

Area to be imaged: .....

Relevant Medical History:

Details (Including any surgery and current medication)

.....

Please include copies of any recent X'ray reports

Safety Check:

Could the patient be pregnant? Yes ☐ No ☐

Is the patient breast feeding? Yes ☐ No ☐

Is the patient a high infection risk? Yes ☐ No ☐

If yes, please specify .....

Is the patient diabetic Yes ☐ No ☐

Is the diabetes controlled by: Diet ☐ Insulin ☐ Tablet ☐

Is the patient on Metformin? Yes ☐ No ☐

Does the patient have any allergies Yes ☐ No ☐

If yes, please specify: .....

Patient arrival:

Stretcher ☐

Wheelchair ☐

Walking ☐

Weight of Patient; .....

Height of Patient: .....

Referring Clinician's Details (To be signed by the Referring Clinician):

Name: .....

Signature: ..... Date: .....

Address: .....

Tel: ..... Fax: .....

Email: .....

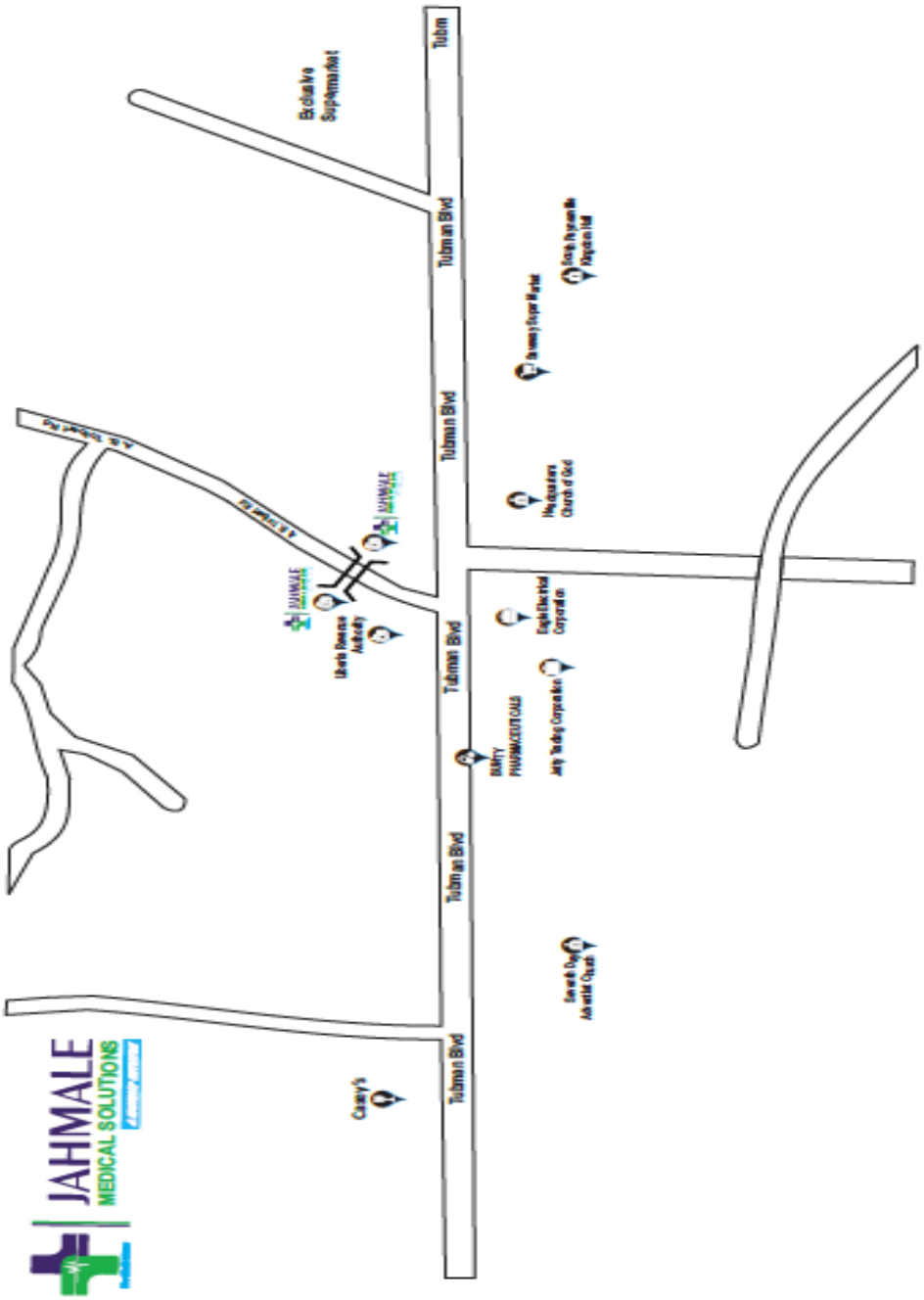
I, certify that the above information is correct and give specific consent for the test(s) to be done. I have received pre-test counseling including a full body scan for MRI procedures. I, undertake to pay outstanding monies not covered by my medical insurance.

Patient's Signature: .....

Amount Billed:	**Amount Paid:**	**Balance:**

Received By:

Form Filled By: **Reg. By:**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