JAHMALE MEDICAL SOLUTIONS	**RADIOLOGY REQUEST FORM – HEAD OFFICE (ELWA JUNCTION)**	
	Doc Number: RF-JMS-RRQF-007	**Revision:** 002
	Approved by: Technical Administrator **Date:** April 2023	**Issued by:** QA Department **Date:** April 2023
	Supersedes: RF-JMS-RRQF-007 (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:

☐ **MRI** ☐ **CT** ☐ **EKG**

Area to be imaged: .....

Creatinine level: ..... Date of Test: .....

Relevant Medical History:

Details (Including any surgery and current medication)

.....

Please include copies of any recent X-ray or scan 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**: .....

To be completed for all MRI examinations

MRI Contraindications – *does the patient have*:

Cochlear implants?	Yes ☐	No ☐
Neurostimulators?	Yes ☐	No ☐
Programmable hydrocephalus shunt?	Yes ☐	No ☐
Metallic foreign body in eye?	Yes ☐	No ☐
Hip implants/prosthesis?	Yes ☐	No ☐
Knee prosthesis?	Yes ☐	No ☐
Spine fusion surgery?	Yes ☐	No ☐
Brain aneurysm clips?	Yes ☐	No ☐
Cardiac pacemakers/valvular implants?	Yes ☐	No ☐
Dental implants?	Yes ☐	No ☐
Other metallic implants?	Yes ☐	No ☐

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

Name: .....

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

Address: .....

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

Email: .....

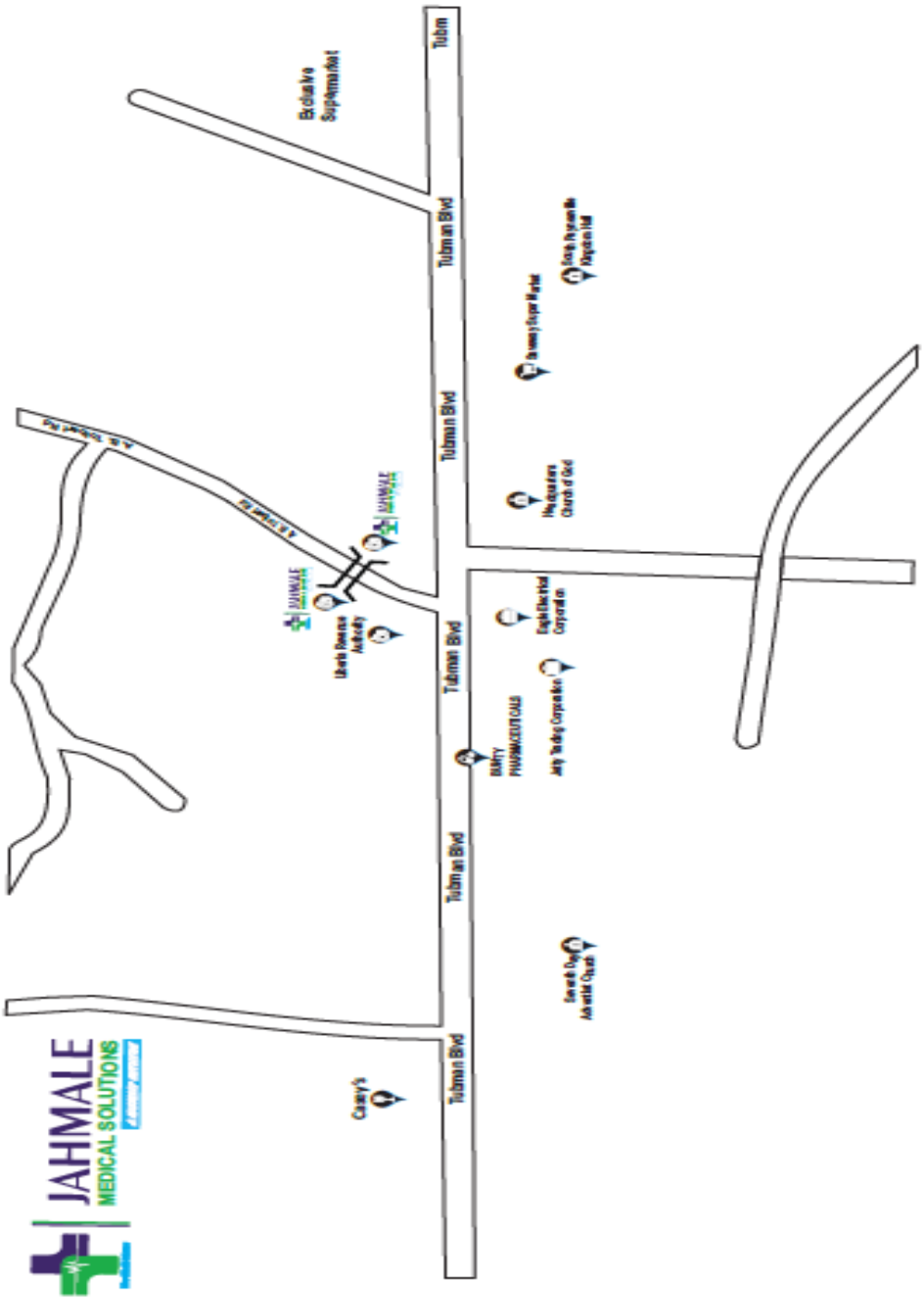
I, certify that the above information is correct and give specific consent for the test(s) to be done. I have received pre-test counseling including a full body scan for MRI procedures. I, undertake to pay outstanding monies not covered by my medical insurance.

Patient's Signature: .....

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

Received By:

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


Tubman Blvd
Tubman Blvd
Tubman Blvd
Tubman Blvd
Tubman Blvd
JAHMALE
MEDICAL SOLUTIONS