RADIOLOGY REQUEST FORM – NEW KRU TOWN (BUSHROD ISLAND)

RF-JMS-RQFN-003	**Revision:** 002
Approved by: Marion Grant-Johnson **Date:** February 2023	**Issued by:** QA Department **Date:** February 2023
Supersedes: RF-JMS-RRQF-001 (001)	**Author:** QA Department
Date Implemented: February 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:

☐ **ULTRASOUND** ☐ **MAMMO** ☐ **EKG** ☐ **ECHO**

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:** ....

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

Name: ....

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

Address: ....

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

Email: ....

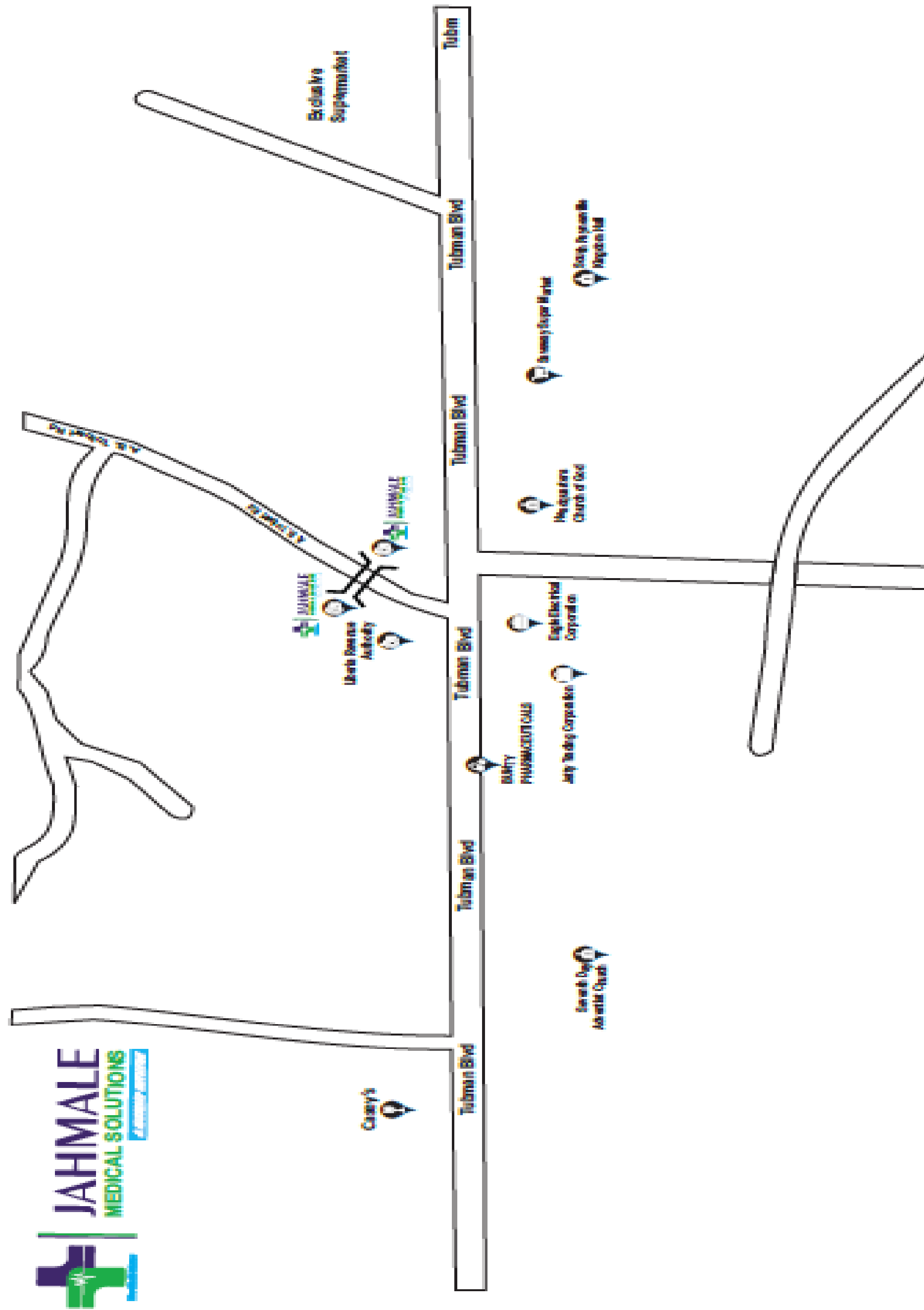
I, certify that the above information is correct and give specific consent for the test(s) to be done. I have received pre-test counseling including a full body scan for MRI procedures. I, undertake to pay outstanding monies not covered by my medical insurance.

Patient's Signature: ....

Amount Billed:	Amount Paid:	Balance:

Received By:

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



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