MRI

PATIENT INFORMATION

SURNAME (Mr, Mrs, Ms) ______________________________ FIRST NAME: ________________________________

DATE OF BIRTH: _______________________ ID No: ______________________________ WEIGHT ________

RESIDENTIAL ADDRESS: ____

P O BOX ADDRESS ____ POSTAL CODE: __________

TEL: Home ________________________________ Work: _____________________________________

NAME OF MEDICAL AID SCHEME: ____

MEDICAL AID NUMBER: ____

WORK INJURY: __________________________________ DATE OF INJURY: _____________________________

IN WHOSE NAME IS THE MEDICAL AID: ____

EMPLOYER'S NAME AND ADDRESS: ____

REFERRED BY DR. ____

IF NOT A MEMBER OF A MEDICAL AID, PLEASE STATE METHOD OF PAYMENT

Cash ☐ Cheque ☐ Credit Card ☐ Debit Card ☐ Medicard ☐ Travellers Cheque ☐

Payment Today? YES ☐ NO ☐

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO ENSURE YOUR SAFETY AND PREVENT ANY INTERFERENCE WITH THE M R SCAN. PLEASE ANSWER THE QUESTIONS AND MARK WITH AN ***X***

	YES	NO	DON'T KNOW
PACEMAKER			
ANEURISM CLIP			
ARTIFICIAL HEART VALVE			
VENA CAVA FILTER			
PROSTHESIS (e.g. Eye, Breast, Etc.)			
COCHLEAR IMPLANTS (ear)			
SHRAPNEL IN EYE OR BODY			
NEUROSTIMULATOR			
ANY OTHER IMPLANTS (e.g. Screws, Plates, Joint Replacements, Etc.)			
ARE YOU PREGNANT?			

I HEREBY ACKNOWLEDGE THAT THE POTENTIAL RISKS OF THE EXAMINATION HAVE BEEN EXPLAINED TO ME AND THAT DURING THE COURSE OF THE INVESTIGATION IT MAY BE NECESSARY FOR THE INTRAVENOUS INJECTION OF A CONTRAST SUBSTANCE.

ATTENTION: - It is the policy of this institution not to discuss results of the MR scans with patients for ethical reasons. All enquiries in this regard should be directed to the referring Physician.

Signature: ______________________________________ Date: ______________________________________