

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 Mediacard 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: _____