

PR. No. 3805948

Reg. No. 2003/031449/21

VAT No. 4100209818

WESTVILLE HOSPITAL

CROMPTON ENTABENI HOSPITAL Tel: 087 310 4981 Fax: 087 236 0681 Tel: 087 310 4983 Fax: 087 236 0683

ANNEXURE D 2.1

HOSPITAL

GATEWAY PRIVATE HOSPITAL Tel: 087 310 4985 Fax: 087 236 0685

DIGITAL MAMMOGRAPHY CENTRE Tel: 087 310 4990 Fax: 087 236 0690

KINGSWAY HOSPITAL Tel: 087 310 4980 Fax: 087 236 0680

ONCOLOGY CENTRE Tel: 087 310 4989 Fax: 087 236 0689 ACCOUNTS: Tel: 087 310 4987 • Fax: 087 236 0687

PARKLANDS HOSPITAL Tel: 087 310 4986 Fax: 087 236 0686

SHIFA HOSPITAL Tel: 087 310 4988 Fax: 087 236 0688

ST. AUGUSTINE'S HOSPITAL Tel: 087 310 4984 Fax: 087 236 0684

Tel: 087 310 4982 Fax: 087 236 0682

PATIENT CONSENT APPLICATION AND CONSENT FOR MRI SCAN ON PATIENT WITH MRI CONDITIONAL / SAFE BRAIN IMPLANT / STIMULATOR PATIENT DETAILS Title: MR MRS MISS MAST ID:						
CONDITIONAL / SAFE BRAIN IMPLANT / STIMULATOR PATIENT DETAILS Title: MR MRS MISS MAST ID:	APPLICATION AND CONSENT FOR MRI SCAN ON PATIENT WITH MRI					
Title: MR MRS MISS MAST ID: Name: Surname:						
Name: Surname: Examination: MRI - MRI Appointment Date: DD/MM/YYYY DOCTORS DETAILS Referring Doctor's Name: Contact Number: Neurosurgeon's Name: Contact Number: ImpLant DETAILS Implant Name: Supplier: Supplier: Dottor's Signature: Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO	PATIENT DETAILS					
Examination: MRI - MRI Appointment Date: DD/MM/YYYY DOCTORS DETAILS Referring Doctor's Name: Contact Number: Neurosurgeon's Name: Contact Number: Neurosurgeon's Name: Contact Number: Implant Name: Supplier: Neurosurgeon's Signature: Date: DD/MM/YYYY Is this the first device inserted ? YES NO	Title: MR MRS	MISS MAST	ID:		7	
MRI Appointment Date: DD/MM/YYYY DOCTORS DETAILS Referring Doctor's Name: Contact Number: Neurosurgeon's Name: Contact Number: ImpLANT DETAILS Implant Name: Supplier: Neurosurgeon's Signature: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO	Name:	Surname:				
DOCTORS DETAILS Referring Doctor's Name: Contact Number: Neurosurgeon's Name: Contact Number: ImpLANT DETAILS Implant Name: Supplier: Code: Neurosurgeon's Signature: Date: DD/MM/YYYY Is this the first device inserted ? YES PATIENT CONSENT	Examination: MRI -					
Referring Doctor's Name: Contact Number: Neurosurgeon's Name: Contact Number: IMPLANT DETAILS Implant Name: Supplier: Neurosurgeon's Signature: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO	MRI Appointment Date:	DD/I	MM/YYYY		-	
Contact Number: Neurosurgeon's Name: Contact Number: IMPLANT DETAILS Implant Name: Supplier: Neurosurgeon's Signature: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO	DOCTORS DETAILS					
Neurosurgeon's Name: Contact Number: IMPLANT DETAILS Implant Name: Supplier: Neurosurgeon's Signature: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO	Referring Doctor's Name:					
Contact Number: IMPLANT DETAILS Implant Name: Supplier: Supplier: Neurosurgeon's Signature: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO	Contact Number:				_	
IMPLANT DETAILS Implant Name: Supplier: Code: Neurosurgeon's Signature: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO PATIENT CONSENT Implant: NO Implant: NO	Neurosurgeon's Name:					
Implant Name: Supplier: Code: Supplier: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO PATIENT CONSENT Implant: NO	Contact Number:					
Supplier: Code: Neurosurgeon's Signature: Date: Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES PATIENT CONSENT	IMPLANT DETAILS					
Neurosurgeon's Signature: Date: DD/MM/YYYY Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES NO PATIENT CONSENT	Implant Name:					
Date of Implant: DD/MM/YYYY Is this the first device inserted ? YES PATIENT CONSENT	Supplier:			Code:		
Is this the first device inserted ? YES NO PATIENT CONSENT	Neurosurgeon's Signature:			Date:	DD/MM/YYYY	
PATIENT CONSENT	Date of Implant: DD/	MM/YYYY				
	Is this the first device inserte	ed ?	YES		NO	
I (Patient Full Name)	PATIENT CONSENT					
	1				(Patient Full Name)	

hereby consent to the MRI scan. The full effects that the scan may have on my implanted brain implant / stimulator and the health risks attached here to, have been explained to me by my Neurosurgeon. I fully absolve Lake, Smit and Partner's or any of it's doctors or staff of any and all responsibility for any complications whilst undergoing the MRI scan and any consequences thereafter.

Patient's Signature:

Date:

DD/MM/YYYY