LAKE, SMIT PARTNERS Inc.

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SPECIALISTS IN DIAGNOSTIC RADIOLOGY

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BOOKINGS EMAIL: central.bookings@lakesmit.co.za TEL: 031 521 0399

TO BE COMPLETED BY REFERRING DOCTOR

DATE

Patient Name & Surname: _____

I.D.: _____

Cell: _____ Age: _____

Email: _____

M/Aid & No.: _____

Tariff Codes: _____

Auth No.: _____

ICD 10 Codes: _____ Ref. Doc.: _____

	ENT	GPH	SAN	WES	PKL	CRO	KGW	HIL	MAM	ETK
General X-ray	●	●	●	●	●	●	●	●		●
Ultrasound	●	●	●	●	●	●	●	●	●	●
Barium Studies	●	●	●	●	●	●	●			●
C.T. Scanning	●	●	●	●	●	●	●	●		●
MRI Scanning	●	●	●	●				●		
Mammography									●	
Nuclear Medicine	●	●								
Interventional	●		●							
Bone Densitometry									●	
PET/CT		●								

CLINICAL HISTORY:

VENUE REQUESTED

- Crompton ☐
- Entabeni ☐
- Gateway ☐
- Hillcrest ☐
- Kingsway ☐
- Mammo ☐
- Parklands ☐
- Westville ☐
- St Augustine's ☐
- Ethekwini ☐

PREGNANT FEMALE Y N **WHEELCHAIR** Y N **BED** Y N

EXAMINATION REQUESTED

- X-Ray ☐
- Ultrasound ☐
- CT ☐
- CT Angiography ☐
- MRI ☐
- Mammography ☐
- Bone Densitometry ☐
- PET/C.T. ☐
- Nuclear Medicine ☐
- Angiography ☐

PLEASE SEND PREVIOUS IMAGING IF AVAILABLE

AUTHORISATION / MOTIVATION FOR MEDICAL AID PURPOSE

A. SUSPECTED CONDITION (CLINICAL HISTORY) NECESSITATING SCAN:

B. INVESTIGATIONS COMPLETED TO DATE FOR THIS CONDITION:

C. WAY IN WHICH THIS SCAN WILL ASSIST IN DEFINING THE PROBLEM

DOCTOR'S NAME

_____
DOCTORS SIGNATURE

REFERRING DOCTOR STAMP HERE

C.T. RISK FACTORS

DIABETIC YES ☐ NO ☐
HYPERTENSIVE YES ☐ NO ☐
ALLERGIES _____
RENAL IMPAIRMENT YES ☐ NO ☐
DIALYSIS YES ☐ NO ☐
LATEST RENAL FUNCTION BLOOD RESULT _____
DATE OF TEST _____
PATIENT ON CHEMOTHERAPY YES ☐ NO ☐
WEIGHT _____
CHECKED WITH _____ IN _____ WARD

M.R.I. RISK FACTORS

ANY PACEMAKER/ANEURYSM CLIPS/NEUROSTIMULATORS YES ☐ NO ☐
ANY METAL IMPLANTS YES ☐ NO ☐
ANY RECENT SURGERY/BIOPSIES YES ☐ NO ☐
DIABETIC YES ☐ NO ☐
HYPERTENSIVE YES ☐ NO ☐
RENAL IMPAIRMENT YES ☐ NO ☐
LATEST RENAL FUNCTION BLOOD RESULT _____
DATE OF TEST _____
PATIENT ON CHEMOTHERAPY YES ☐ NO ☐
WEIGHT _____
CHECKED WITH _____ IN _____ WARD