



**ADVANCED IMAGING & THERAPY CENTRE**

139 Felix Dlamini Road, Overport, Durban, KZN, 4001  
Bookings - Tel:+27 (0)31 207 6817/6671 / +27 (0)31 271 3018  
Cell: +27 (0)74 850 9078 / +27 (0)83 777 1717  
Fax: +27 (0)31 207 3226  
Email: advanced.imaging.centre@gmail.com  
Website: www.imaging-therapy.com

**Bookings:**

PET/CT, SPECT/CT, ULTRASOUND, CT SCAN, XRAY, MAMMOGRAM, DEXA  
ALL OTHER NUCLEAR MEDICINE STUDIES

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A. Other associated/ co-morbid clinical conditions (clinical history):

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B. Relevant Biochemistry and Histology:

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C. Investigations completed to date for this condition:

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Examination/ Study requested:

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Referring Doctor Name: _____
Signature: _____
Tel/ Cell: _____ / _____
E-mail Address: _____
Pr. No: _____ Speciality: _____

Booking Date/Time \_\_\_/\_\_\_/\_\_\_ : \_\_\_H\_\_\_

**Please send previous X-RAYS/ CT/MRI on CD**



**Dr Masha Maharaj**  
MBBCh, FCNP, MMED (Nuclear Medicine)  
Specialist Nuclear Physician

**Dr R. Jackpersad**  
MBChB, FC Rad (SA)  
Specialist Radiologist



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Pr No: 0647691

**PATIENT INFORMATION**

Title \_\_\_\_\_ Initial \_\_\_\_\_ Patient's Surname \_\_\_\_\_  
First Name \_\_\_\_\_  
Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ I.D. \_\_\_\_\_  
Relation to Member \_\_\_\_\_ Dependents No \_\_\_\_\_  
**Female Patients:** Are you pregnant? Yes / No LMP \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

Title \_\_\_\_\_ Initial \_\_\_\_\_ Surname \_\_\_\_\_ First Name \_\_\_\_\_  
ID no \_\_\_\_\_ Med. Aid Name \_\_\_\_\_ No \_\_\_\_\_  
Postal Address \_\_\_\_\_ Code \_\_\_\_\_  
Res. Address \_\_\_\_\_ Code \_\_\_\_\_  
Tel. (Home) \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_  
Employer: (Company Name) \_\_\_\_\_  
Work Address \_\_\_\_\_  
Tel (Work): \_\_\_\_\_ Fax \_\_\_\_\_ Occupation \_\_\_\_\_  
Relative/Friend (Not living with Patient) \_\_\_\_\_ Tel \_\_\_\_\_  
Address of Relative/Friend \_\_\_\_\_ Code \_\_\_\_\_

**TO BE COMPLETED BY THE REFERRING DOCTOR**

Please fill in **ICD-10 CODE** .....

Clinical details/Motivation for Examination/Study requested

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