Sandton CT Scanner DEPT

NAME: _____

DATE OF BIRTH: _____

WEIGHT: _____

MED AID AUTHORIZATION NUMBER: _____

Please be advised that any specialized Radiology co-payments must be settled on the day of examination.

Have you had any surgery relating to your problem? _____

Have you had any previous examinations relating to your problem?

_____

___

Are you allergic to Iodine? _____

Female patients: Is there any possibility you may be pregnant? _____

I consent to the injection of Contrast Medium If indicated .

SIGN: _____

Parent or Guardian. _____

Date: _____