PLATINUM HEALTH

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Radiology Authorisation Request Form

APPROVED: ☐ DECLINED: ☐

Authorisation number: Date: C C Y Y M M D D

Patient (Full name and surname):

Date of birth: C C Y Y M M D D Dependant code:

Main member (Full name and surname):

Medical Scheme Number: Patient contact no:

Referring Doctor (Full name and surname):

Practice number: Contact no:

Diagnostic Radiologist (Full name and surname):

Practice number: Contact no:

Date of appointment: C C Y Y M M D D Time of appointment :

Special Investigation Requested:

☐ Ultrasound – Region:

☐ Isotope scan – Region:

☐ CT scan – Region:

☐ MRI scan – Region:

☐ Pet scan – Region:

Clinical information/Motivation/History:

Platinum Health site: Referring doctor signature:

PLEASE PRINT, SIGN AND FAX OR E-MAIL BACK TO CASE MANAGEMENT

Fax: 086 247 9497, 086 233 2406 or 086 233 1656 / E-mail: plathealth@platinumhealth.co.za