parklane radiology

X-RAY REQUEST FORM

NETCARE PARK LANE HOSPITAL
Lower Ground Floor
12 Junction Avenue, Parktown
Tel: 011 484 4642
Email: reception@plradiology.co.za

PRACTICE NUMBER: 0359041

Patient Name: .....

Medical Aid: ..... Medical Aid Number: .....

X-RAY

☐ SKULL	☐ FOREARM	☐ PELVIS	☐ FOOT
☐ MANDIBLE	☐ ELBOW	☐ HIP	☐ CERVICAL SPINE
☐ SINUSES	☐ HAND	☐ FEMUR	☐ THORACIC SPINE
☐ PNS	☐ WRIST	☐ KNEE	☐ LUMBAR SPINE
☐ SHOULDER	☐ CHEST	☐ TIB-FIB	
☐ HUMERUS	☐ ABDOMEN	☐ ANKLE	

ULTRASOUND

☐ THYROID	☐ VASCULAR	☐ JOINT	☐ SOFT TISSUES
☐ BREAST	☐ SCROTAL	☐ ABDOMEN & PELVIS	

CT

☐ ABDOMEN (KUB) / NON CONTRAST	☐ BRAIN NON CONTRAST
☐ ABDOMEN & PELVIS PRE & POST	☐ BRAIN PRE & POST
☐ SINUSES	☐ TEMPORAL BONES
☐ CHEST(HRCT)	☐ NECK
☐ CHEST PRE & POST	☐ CT PULMONARY ANGIOGRAM

MRI

☐ BREAST	☐ NECK	☐ SPINE	☐ KNEE
☐ PELVIS	☐ WB DWI	☐ OTHER	

HISTORY / CLINICAL FINDINGS **URGENT** ☐

REFERRING DOCTOR:

Name: ..... ICD 10 Code: .....

Signature: ..... Date: .....

A Valid Medical Aid Card as well as the main member's I.D number are required
Authorisation by the medical aid has to be arranged by the patient