ERAD
Leading Radiology

ERADW-11

Referral Form

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SPECIALIST RADIOLOGISTS:
Dr JM Kabongo
Dr LA Madisha

Accession number: .... Appointment Date: .... / .... / .... Appointment time: ....h ....

Surname: ....

Initials: .... Title: .... ☐ Female ☐ Male DOB: .... / .... / ....

Postal Address: .... LMP: ....

Medical AID number: ....

Main Member Surname: .... Initials: ....

CLINICAL HISTORY:

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ICD 10: .... Iodine Allergy: ....

Urea: .... Creatinine: .... eGFR: ....

NATURE OF EXAM:

....

....

....

Referring Doctor: .... Date: .... / .... / ....

Referring Doctor Practice Number / Stamp: ....

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