Medical Imaging
GHANA LTD.

17 Ridge Road, Roman Ridge. PMB 31, Kanda-Accra
Tel: +233 (0) 302 784770 / 784771 Fax: +233 (0) 302 778013
E-mail: medlab@medlab.com.gh

REQUEST FORM

SURNAME

FIRST NAMES

ID No.

DATE OF BIRTH (D D M M Y Y) AGE SEX M F

REF./FILE No.

FULL NAMES

GUARANTOR ID NUMBER

POSTAL ADDRESS

I give consent to do tests and guarantee payment of any amount not covered by Medical Aid or exceeding estimate and verify that all information given is correct.

MIG Number:

DELIVER REPORT ?:

Yes ☐ No ☐

PAYMENT:

By Patient ☐

Monthly Billing ☐ (only by prior arrangement)

Signature:

TEL HOME: CELL NO:

EMPLOYER: TEL WORK:

E-MAIL

RADIOLOGIST'S REPORT: YES / NO

DOCTOR'S NAME:

DOCTOR'S SIGNATURE:

TEL: FAX: DATE:

INVESTIGATION REQUESTED:

CLINICAL HISTORY:

Receipt No:	Amount Paid: GH¢	Received By: