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REQUEST FORM

PATIENT DETAILS		PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT	
SURNAME		FULL NAMES , , , , , , , , , , , , , , , , , , ,	
FIRST NAMES		GUARANTOR ID NUMBER	
ID No.		POSTAL ADDRESS	
DATE OF BIRTH AGE SEX M F			
REF./FILE No.			
I give consent to do tests and guarantee payment of any amount not covered by Medical Aid or exceeding		TEL HOME:	CELL NO:
estimate and verify that all information give	ven is correct.	EMPLOYER:	TEL WORK:
MIG Number:	PAYMENT:	E-MAIL	
	By Patient	RADIOLOGIST'S REPORT: YES / NO	
	Monthly Billing (only by prior arrangement)	DOCTOR'S NAME:	
DELIVER REPORT ?:	arrangement)	DOCTOR'S SIGNATURE:	
Yes No No	Signature:		FAX:DATE:
INVESTIGATION REQUESTED:			
CLINICAL HISTORY:			
Receipt No: Amount		Paid: GH¢	Received By: