



MORTON & PARTNERS

RADIOLOGISTS

Practice no: 3803325

For more information about procedures and branches please visit our website www.morton.co.za

IT/PACS Support: 021 276 2019 (o/h)
083 607 4613 (a/h)

Xero Viewer: mobile.morton.co.za

Portal: portal.morton.co.za

REFERRAL LETTER

PATIENT INFORMATION

PATIENT	
ID NUMBER	DOB:
MEDICAL AID	MED AID No:
WCA	DATE OF INJURY
WARD	COMPANY
	DATE

URGENT: PLEASE CONTACT REFERER WITH RESULTS TEL:

CLINICAL INDICATIONS	ICD 10
-----------------------------	---------------

<input type="checkbox"/> XRAY	<input type="checkbox"/> ULTRASOUND	<input type="checkbox"/> BMD	<input type="checkbox"/> MAMMOGRAPHY	<input type="checkbox"/> INTERVENTION
CT <input type="checkbox"/> BRAIN <input type="checkbox"/> FACIAL BONES <input type="checkbox"/> PARANASAL SINUSES <input type="checkbox"/> IAMS <input type="checkbox"/> CORONARY CALCIUM SCORE <input type="checkbox"/> CHEST <input type="checkbox"/> HRCT <input type="checkbox"/> NECK, CHEST, ABDO, PELVIS <input type="checkbox"/> CHEST ABDO PELVIS <input type="checkbox"/> ABDOMEN TRIPHASIC <input type="checkbox"/> ABDO AND PELVIS <input type="checkbox"/> PELVIS <input type="checkbox"/> RENAL TRACT FOR STONE <input type="checkbox"/> COLONOGRAPHY <input type="checkbox"/> CERVICAL - SPINE <input type="checkbox"/> THORACIC - SPINE <input type="checkbox"/> LUMBAR - SPINE	<input type="checkbox"/> SACRUM <input type="checkbox"/> BONY PELVIS CT OTHER CT ANGIOGRAM <input type="checkbox"/> NECK AND BRAIN VESSELS <input type="checkbox"/> THORACIC AORTA <input type="checkbox"/> ABDOMINAL AORTA <input type="checkbox"/> TAVI <input type="checkbox"/> AORTA AND OUTFLOW <input type="checkbox"/> CORONARY ARTERIES <input type="checkbox"/> PULMONARY ANGIO PROCEDURES CT INTERVENTION <input type="checkbox"/> CT PLANNING <input type="checkbox"/> GUIDANCE <input type="checkbox"/> LOCALISATION <input type="checkbox"/> ABSCESS/CYST DRAINAGE <input type="checkbox"/> FNA BIOPSY <input type="checkbox"/> CUTTING NEEDLE BIOPSY	<input type="checkbox"/> JOINT INJECTION <input type="checkbox"/> NERVE BLOCK <input type="checkbox"/> FACET BLOCK <input type="checkbox"/> SI JOINT BLOCK UNI/BILATERAL <input type="checkbox"/> LUMBAR PUNCTURE <input type="checkbox"/> OTHER INTERVENTION MRI NEURO AND SPINE <input type="checkbox"/> BRAIN <input type="checkbox"/> MRA INTRACRANIAL <input type="checkbox"/> MRA NECK VESSELS <input type="checkbox"/> HYPOPHYSIS <input type="checkbox"/> IAMS <input type="checkbox"/> BRACHIAL PLEXUS <input type="checkbox"/> LUMBOSACRAL PLEXUS <input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> SACRUM	MRI BODY <input type="checkbox"/> CHEST <input type="checkbox"/> LIVER/PANCREAS <input type="checkbox"/> MRCP <input type="checkbox"/> MR ENTEROGRAPHY <input type="checkbox"/> KIDNEYS <input type="checkbox"/> PELVIS/PROSTATE <input type="checkbox"/> WHOLE BODY METS SCREEN MRI OTHER <input type="checkbox"/> DIFFUSION <input type="checkbox"/> SPECTROSCOPY MRI HEAD AND NECK <input type="checkbox"/> ORBITS <input type="checkbox"/> FACE <input type="checkbox"/> TM JOINTS <input type="checkbox"/> SALIVARY GLANDS <input type="checkbox"/> EAR <input type="checkbox"/> SOFT TISSUE NECK	MRA VESSELS <input type="checkbox"/> THORACIC AORTA <input type="checkbox"/> UPPER LIMB ANGIO <input type="checkbox"/> ABDOMINAL AORTA <input type="checkbox"/> LOWER LIMB ANGIO MRI MSK <input type="checkbox"/> SHOULDER <input type="checkbox"/> UPPER ARM <input type="checkbox"/> ELBOW <input type="checkbox"/> FOREARM <input type="checkbox"/> WRIST <input type="checkbox"/> BONY PELVIS <input type="checkbox"/> HIP JOINTS <input type="checkbox"/> THIGH <input type="checkbox"/> KNEE <input type="checkbox"/> LEG <input type="checkbox"/> ANKLE <input type="checkbox"/> FOOT

SIGNATURE : NO SIGNATURE REQUIRED FOR DIGITAL EMAIL SUBMISSIONS

REFERRED BY: Tel: Cell:

PRACTICE No: Email:

<ul style="list-style-type: none"> • NO APPOINTMENTS REQUIRED FOR X-RAYS • MRI BOOKINGS ONLY: 021 276 1253 	OPENING HOURS: Mon - Fri 08h00 - 17h00 Saturdays 08h30 - 12h00 Closed - Sun and Public Holidays
--	---

SELECT THE BRANCH REQUIRED BELOW AND WHEN READY CLICK SUBMIT FORM. THE COMPLETED FORM WILL BE ATTACHED TO THE EMAIL GENERATED:

SUBMIT FORM PLEASE NOTE THAT DIGITAL SUBMISSIONS ARE ONLY PROCESSED DURING NORMAL OPERATING HOURS

PLEASE NOTE:

- The following is required when arriving for your appointment:
 - ID or passport • Medical Aid Card (if applicable)
 - Referral Letter
- PRIVATE patients & patients without a valid MEDICAL AID card MUST PAY for their procedures on the day.
- WCA patients MUST BRING A SIGNED & DATED DOCTOR'S REFERRAL & WCL2 FORM as per WCA requirements.