NHLS - HUMAN GENETICS

DIAGNOSIS:

SURNAME:

APPOINTMENTS:

Date:_____ h_____ At:_____ By:_____

Date:_____ h_____ At:_____ By:_____

Date:_____ h_____ At:_____ By:_____

Date:_____ h_____ At:_____ By:_____

Date:_____ h_____ At:_____ By:_____

Hospital: _____

No: _____ Fin Class: _____

Medical Aid: _____

Medical Aid No: _____

Member: _____ I.D. No: _____

REFERRED BY:

Name: _____

Address: _____

Tel: _____ Fax: _____

Name: _____

Address: _____

Tel: _____ Fax: _____

Index Name(s): _____

Date of Birth: _____

Name(s) Ms: _____

Maiden Name: _____

Date of Birth: _____

Occupation: _____

Name(s): Mr: _____

Date of Birth: _____

Occupation: _____

Street Address: _____

_____ Code: _____

Postal Address: _____

_____ Code: _____

Telephone: (H)_____ Contact: _____

(W) Ms: _____ Mr: _____

Fax: Ms: _____ Mr: _____

Cell: Ms: _____ Mr: _____

E-mail: Mr: _____

Ms: _____

Booking taken by: _____ Phoned in by: _____ Date: _____ Faxed/Posted

Booking Confirmed: 1)_____ 2)_____ 3)_____ 4)_____ 5)_____

Previously counselled: Y/N Date: _____ Where: _____

Previous genetic tests: Y/N Date: _____ Where: _____

BILLING

Private Patient: ☐ State Patient: ☐

CGC Number	Date	Billed	Initial	Review	Enter

OTHER TESTS

MISSION PRINT (011) 425-3964