Life HEALTH CARE Brooklyn Day Hospital

Impilo Patient Information form

In case of a pre-admission please fax, e-mail or hand in at admissions ASAP - fax 012 346 6350 / bdh@lifehealthcare.co.za

Should you have any queries please contact reception for assistance on telephone 012 433 0860

HOSPITAL USE ONLY		
DOCTOR:	**SURGERY BOOKED TIME:**	**TIME OF ARRIVAL:** 0
WARD DETAILS:	**BED DETAILS:**	**PRE-ADMISSION NUMBER:**

PATIENT INFORMATION

PATIENT'S PERSONAL INFORMATION

IDENTIFIER TYPE: ID NUMBER /PASSPORT NUMBER /PATIENT LIFE NUMBER		IDENTIFIER NUMBER:	
SURNAME:	NAME:		INITIALS:
OTHER NAMES:		KNOWN AS:	
TITLE : DR /FR /MISS /MR /MRS /MS /PROF /REV	GENDER: MALE / FEMALE	DATE OF BIRTH :	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
PREFERRED METHOD OF CONTACT? MOBILE / WORK / HOME / EMAIL	RECEIVE MARKETING? Y / N	RECEIVE STATEMENTS? Y / N	
EMAIL ADDRESS:			
RESIDENTIAL ADDRESS:		POSTAL ADDRESS:	
SUBURB:		SUBURB:	
CITY	CODE:	CITY	CODE:
MARITAL STATUS: SINGLE /MARRIED /DIVORCED	DIETARY PREFERENCE : FRUITARIAN / HALAAL / KOSHER / NONE / VEGAN / VEGETARIAN		
RELIGION:	CONGREGATION	MINISTER	

EMERGENCY CONTACT (PERSON TO BE CONTACTED IN CASE OF A MEDICAL EMERGENCY)

SURNAME:	NAME:		
RELATIONSHIP TO PATIENT: CHILD / FRIEND / PARENT / GUARDIAN / RELATIVE / SIBLING / SPOUSE			
MOBILE NUMBER:	EMERGENCY CONTACT'S ADDRESS:		
WORK NUMBER:		SUBURB:	
HOME NUMBER:	CITY:		CODE:

ALTERNATIVE CONTACT: (PERSON NOT LIVING AT THE SAME ADDRESS)

SURNAME:	NAME:		
RELATIONSHIP TO PATIENT: CHILD / FRIEND / PARENT / GUARDIAN / RELATIVE / SIBLING / SPOUSE			
MOBILE NUMBER:	ALTERNATIVE'S CONTACT'S ADDRESS:		
WORK NUMBER:		SUBURB:	
HOME NUMBER:	CITY:		CODE:

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MEDICAL AID INFORMATION (PLEASE RECORD DETAILS AS PER MEDICAL AID CARD)

MEDICAL AID SCHEME:		PLAN:	
MEMBER NUMBER:		AUTHORISATION NUMBER:	
PRINCIPAL MEMBER SURNAME:		NAME	
INITIALS:	TITLE : DR / FR / MISS / MR / MRS / MS / PROF / REV	SA ID NUMBER:	
DATE OF BIRTH :	GENDER: MALE / FEMALE	DEPENDANT CODE:	

HOSPITAL VISIT INFORMATION

ADMISSION DATE:	**SURGERY BOOKED DATE:**	**TIME:**
ADMITTING DOCTOR:	**REFERRING DOCTOR:**	
ALTERNATE DOCTOR:	**GENERAL GP:**	
ICD CODE / DIAGNOSIS:		
CPT CODE / PROCEDURE:		

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR THIS ACCOUNT)

IDENTIFIER TYPE: ID / PASSPORT / PATIENT LIFE NUMBER/NOT ASSIGNED		IDENTIFIER NUMBER:	
SURNAME:	NAME:	INITIALS:	
OTHER NAMES:	KNOWN AS:		
TITLE : DR / FR / MISS / MR / MRS / MS / PROF / REV	GENDER: MALE / FEMALE	DATE OF BIRTH :	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
PREFERRED METHOD OF CONTACT: MOBILE / WORK / HOME / EMAIL	RECEIVE MARKETING? Y / N	RECEIVE STATEMENTS? Y / N	
EMAIL ADDRESS:			
RESIDENTIAL ADDRESS:		POSTAL ADDRESS:	
SUBURB:		SUBURB:	
CITY:	CODE:	CITY:	CODE:

CLINICAL INFORMATION

PLEASE PROVIDE A BRIEF DESCRIPTION OF THE SYMPTOMS/COMPLAINTS PRESENT WHEN VISITING THE DOCTOR:

SHOULD YOU BE SUFFERING FROM DIABETES MELLITUS PLEASE INDICATE WHICH FORM OF CONTROL IS BEING PRACTICED?	TABLETS	INSULIN	DIET	NONE

DO YOU SUFFER FROM ANY OF THE FOLLOWING CHRONIC CONDITIONS/ILLNESS? (PLEASE INDICATE BELOW)

HYPERTENSION	MULTIPLE SCLEROSIS	CHOLESTEROL	EMPHYSEMA	ASTHMA	EPILEPSY	THYROID DISORDER	LUPUS
DEPRESSION	HEART FAILURE	PORPHYRIA	OTHER:				

PATIENTS PLEASE TAKE NOTE OF THE FOLLOWING:

1. **PRIVATE PATIENTS -** A prepayment is required on hospitalisation from patients not covered by medical aid. It is suggested that private patients contact the accounts department prior to admission to establish the estimated hospital cost.
2. **MEDICAL AID PATIENTS –** Please consult with your medical aid prior to admission obtaining pre-authorisation if necessary. Any short payments by your medical aid will be for your own account.
3. **MEDICAL AID CARD AND ID BOOK –** Must be produced on admission otherwise patient will be treated as private.
4. **PRIVATE/SEMI PRIVATE WARDS –** Medical aid patients requesting private wards will be expected to pay the private ward rate on admission. Please note private wards are subject to availability.

I _____ hereby declare that the information I have provided is true and correct and agree to the terms and conditions as set out above.

Patient Signature _____ **Date of Signature** _____