cure
DAY CLINICS
MIDSTREAM

Cure Day Clinics-Midstream (Pty)Ltd • Reg: 2010/010726/07 • PR NR: 0423556
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PRE-ADMISSION FORM

Doctor's Information

Name of Dr: .... Practice No: ....

Diagnosis: .... ICD Code: ....

Procedure: ....

Date of Procedure: ....

Please FAX or E-MAIL 48 hours prior to admission

Please complete - Full details of patient

Surname: .... Full names: ....

Sex: *Male* ☐ *Female* ☐ Date of birth: ....

Preferred language: *English* ☐ *Afrikaans* ☐ Dependant code: ....

ID No: .... Cell No: ....

Person responsible for account (Main member of Medical Aid)

Medical Fund: .... Option: ....

Title: *Mr* ☐ *Mrs* ☐ *Ms* ☐ *Child* ☐ *Dr* ☐ *Prof* ☐ Member No: ....

ID of Main member: .... Authorization No: ....

Main member's surname: .... Initials: ....

Postal address: .... Physical address: ....

.... Code: ....

.... Code: .... Email: ....

Tel: (H) .... Cell: ....

Employer's Detail (Main member/Person responsible for account)

Company name: .... Tel No: (W) ....

Postal address of employer: .... Occupation: ....

.... Postal Code: ....

Person to contact in case of emergency/Next of kin

(Different address and tel)

Surname: .... Initials: .... Title: ....

Tel No: (W) .... Tel: (H) .... Cell: ....

Relationship to patient: ....

Main member / Person responsible for account

I, (Full names) .... give Cure Day Clinics Midstream the authority to claim/submit the account(s) on my behalf to ....(Medical Aid),

Member No: ....

Date: ....

Signature

I hereby confirm all details supplied on this form are correct.

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PREOPERATIVE SCREENING CHECKLIST

Patient (full names and surname): ....

Date of birth: ....

Height [ ] Weight [ ] BMI [ ]

(For office use)

Contact telephone number: ....

Operation: ....

Surgeon: ....

Date of surgery: ....

QUESTIONNAIRE

Kindly tick the relevant box or provide us with the necessary information:

Question	Y / N
Do you have Medical aid/insurance? If not, how will you pay for the procedure?	Y N
If you are on a Medical aid, did you check with your scheme whether a co-payment applies?	Y N
Are you aware you need to call if there is any reason you can't come on the day of the surgery?	Y N
Do you have someone to drive you home after your surgery?	Y N
Are you aware that you shouldn't eat or drink anything on the day of your surgery?	Y N
Do you have any allergies to medication/food/ latex/plaster/other? Please provide details of your allergies:	Y N
Will you be walking into the hospital? If not, how will you enter the building?	Y N
What previous operations have you had?	
What problems have you experienced with previous anaesthesia?	
Have you experienced/suffered from the following: porphyria, malignant hyperthermia, scoline apnoe?	Y N
Are you able to do fast walking, climb a flight of stairs or do moderate house work?	Y N
Do you have any heart problems (chest pain, heart attack, irregular heartbeat, heart failure)?	Y N
Do you have problems with high / low blood pressure?	Y N
Can you sleep flat at night?	Y N
Do you have lung problems (asthma, emphysema, bronchitis, chronic coughing)?	Y N
Do you suffer from the following: heavy snoring, choking, gasping or stop breathing while asleep?	Y N
Do you have a current infection (cold, skin infection, urinary tract infection, other)?	Y N
Do you get heartburn/reflux?	Y N
Do you have a stomach or peptic ulcer?	Y N
Do you suffer from diabetes or thyroid problems?	Y N
Do you suffer from liver problems, jaundice / hepatitis? If past, when?	Y N
Do you suffer from kidney or bladder problems?	Y N
Have you had problems with blood clots or embolisms in your lungs or legs?	Y N
Do you have prolonged bleeding after an injury?	Y N
Have you taken aspirin, arthritis medicine, warfarin or other blood thinners in the last week?	Y N
Do you suffer from epileptic convulsions or blackouts of any sort?	Y N
Do you suffer from muscle weakness or a stroke?	Y N
Are you pregnant or currently breast feeding?	Y N
Do you have false, loose, or crowned teeth? If so, where?	Y N
Are you a smoker? If so, how many per day?	Y N

CURRENT MEDICATION HISTORY (list all that apply, including herbal supplements and over-the-counter medication)

MEDICATION	DOSE	COMMENTS