Cure Day Clinics Bloemfontein (Pty)Ltd • Reg. No: 2012/018389/07 • PR No: 0561851
Free State Medical Centre, 29 Poole Street, Brandwag, Bloemfontein, 9324
Private Bag X25, Elarduspark, Pretoria, 0047
Tel: 051 824 1240 • Fax: 021 824 1254 • Email: admissions@cdc-bloemfontein.co.za
www.curedayclinics.co.za

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 Bloemfontein 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.*

cure DAY CLINICS

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:

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

SUBMIT