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Maternity Application Form

IMPORTANT NOTE: Any consultation or procedure not listed requires pre-authorisation by calling Prime Cure - 0861 665 665 or emailing maternity@primecure.co.za. Pre-authorisation number should be recorded on the account to be considered for payment. Please submit your account electronically using the following destination code - 642P, alternatively post claims to: Prime Cure, Private Bag 2108, Houghton, 2041.

A Patient Details:

Medical Scheme Plan: ______________________ Member Number: ______________________

Title: __________ Surname: ______________________

First Name: ______________________ Email: ______________________

Identity Number/Passport: ______________________ Date of Birth: ______________________

Tel: ______________ Fax: ______________ Cell: ______________

B Patient Medical History:

Height __________ Weight __________

Have you had a Pap smear?

Yes No If yes, please provide date of test ______________ and the results: ______________

Do you have a personal or family history of breast, ovarian, or uterine cancer?

Yes No

Smoker:

Yes No Ave per day: __________

Alcohol:

Yes No Units per week: __________

Other substance use details: ______________________

Exercise:

Frequency: Hours per week __________ Type: ______________ Intensity: Low Medium High

Chronic Conditions:

Cardiovascular Endocrine Respiratory Psychiatric HIV Other

Specify: ______________________

C Current Pregnancy Details:

Last Menstrual Period: ______________ Expected Date of Delivery: ______________

Weeks Pregnant: ______________ Previous Pregnancies (including current pregnancy): ______________

Number of Live Births: __________ Is this a multiple pregnancy: Yes No If yes, Twins Triplets

Have you had any antenatal scans?

Yes No If yes, were any problems detected: Yes No

Specify: ______________________

Are you currently suffering from any of the following pregnancy induced conditions:

Gestational Hypertension Gestational Diabetes

Mode of Delivery: (planned)

Normal Vaginal Birth Caesarian Section

If yes, please select indication: Elective Caesarian Previous Caesar Multipe Births High Risk Pregnancy

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D Previous Pregnancy Details:

Have you ever had a multiple pregnancy?

Yes No If yes, Twins Triplets

Have you previously had a miscarriage or a stillbirth?

Yes No If yes, please provide details:

Year of miscarriage/stillbirth: ____________ Gestation at miscarriage/stillbirth: ____________

Did you experience any of the following during previous pregnancies?

Small for Gestational Age Gestational Hypertension Gestational Diabetes

Preterm Labour Pre-Eclampsia Placenta Previa

E Previous Delivery Details:

Normal Vaginal Birth:

Yes No Number: ____________

Caesarian Section:

Yes No Number: ____________

Did you experience any of the following during a vaginal birth?

Induced Labour Forceps Vacuum Extraction Complications

If yes, please provide details: ____________

Please provide reasons for the caesarian delivery:

Elective Caesarian Emergency Caesarian Previous Caesar High Risk Pregnancy Other

If Other, please provide details: ____________

Did you experience any of the following complications after the birth of your children?

Placental Retention Severe Bleeding Postpartum Infection Breast Feeding Problems Postpartum Depression

F Medical Practitioner Details:

General Practioner Surname: ____________ Initials ______ Practice No: ______

Telephone number: ____________ Fax number: ____________

Gynae/Obstetrician Surname: ____________ Initials ______ Practice No: ______

Telephone number: ____________ Fax number: ____________

Midwife Surname: ____________ Initials ______ Practice No: ______

Telephone number: ____________ Fax number: ____________

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G Declaration:

I ____ ID no _________________________________ declare that all the information supplied is to my best knowledge true and correct. I may not hold the Managed Care Company, liable from any of my ommitted information. I consent that the supplied information may be shared amongst contracted health care personnel in order to grant me the best possible care based on approved protocols as per Prime Cure.

I consent to the health care workers responsible for my treatment and/or management in terms of the Programme providing the Programme's health care workers with the clinical information pertaining to my current pregnancy, and the treatment and management thereof. To the healthcare providers sharing the above-mentioned information with any other health care worker involved with my care or management (including hospital risk management professionals appointed by the Medical Scheme/Health Insurer or the Scheme's administrator). Provided that no clinical information regarding my health condition will be available to my employer(s) or any other person not involved in my health care, without my express written consent.

I acknowledge that whilst Prime Cure shall use its best endeavours to uphold the confidentiality of all information disclosed to it, Prime Cure shall not be liable for any claims by me or my dependents arising from any unintentional unauthorised disclosure of my personal information, my medical information pertaining to my health condition and the treatment and management thereof to a third party; or as a result of Prime Cure having to use ICD 10 codes when filing a claim for payment with the Medical Scheme.

Patient Electronic Signature: ____________________ Date: ____________________