

NETCARE ADMISSION FORM**PATIENT DETAILS ***

Title		Surname	
First Name(s)			Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
ID / Passport No.		Date of Birth	Age
Nationality		Language	Religion
E-mail Address			
Home Tel No.		Cellphone No.	

Physical Address*	Unit No.		Complex Name	
Street No.	Street Name			
Suburb / District		City / Town		Post Code
Postal Address*	PO Box / Private Bag			
Suburb / District		Country		Post Code

Employment Information				
Name of Company				Occupation
Employee No.		Work Tel No.		

Physical Address*	Unit No.		Complex Building Name	
Street No.	Street Name			
Suburb / District		City / Town		Post Code

Contact Person				
Surname				
First Name(s)				Relationship to Patient
Home Tel. No.		Work Tel. No.		Cellphone No.

Other Contact Person (not residing with you)				
Surname				
First Name(s)				Relationship to Patient
Home Tel. No.		Work Tel. No.		Cellphone No.

IF INTERNATIONAL PATIENT

International*	Unit No.		Complex Name	
Street No.	Street Name			
Suburb / District		City / Town		Post Code

* In the case of non-South African resident patients, record physical and postal address in country of origin, and record details of contact persons both in the Patient's country of origin and in South Africa, if possible.

ADMISSION DETAILS

Admitting Doctor		Referring Doctor	
Family Doctor/GP			
Patient Diagnosis			
Date of Procedure		Procedure Code	
Date of Admission			
Ward Type	General <input type="checkbox"/>	Private* <input type="checkbox"/>	Semi-Private* <input type="checkbox"/>

* To be charged and paid for privately (if available)

PATIENT MEDICAL AID DETAILS

Medical Aid / Medical Insurance			
Medical Aid No. / Policy Number			
Plan / Option			
Dependant Code (Patient)		Waiting Period (Patient)	
Authorisation No.		Benefit Date	

Medical Aid Membership Card and ID Document must be Produced on Admission

MAIN MEMBER DETAILS

Title		Surname	
First Name(s)			Relationship to Patient
ID / Passport No.		Date of Birth	Age
Nationality		Language	Religion
E-mail Address			
Home Tel No.		Cellphone No.	

MAIN MEMBER DETAILS (continued)

Physical Address*	Unit No.	Complex Name	
Street No.	Street Name		
Suburb / District	City / Town		Post Code
Postal Address*	PO Box / Private Bag		
Suburb / District	Country	Post Code	

Employment Information

Name of Company	Occupation	
Employee No.	Work Tel No.	

Physical Address*	Unit No.	Complex Building Name	
Street No.	Street Name		
Suburb / District	City / Town		Post Code

PERSON RESPONSIBLE FOR ACCOUNT (other than patient or main member)

Title	Surname	
First Name(s)	Relationship to Patient	
ID / Passport No.	Date of Birth	Age
Nationality	Language	Religion
E-mail Address		
Home Tel No.	Cellphone No.	

Physical Address*	Unit No.	Complex Name	
Street No.	Street Name		
Suburb / District	City / Town		Post Code
Postal Address*	PO Box / Private Bag		
Suburb / District	Country	Post Code	

Employment Information

Name of Company	Occupation	
Employee No.	Work Tel No.	

Physical Address*	Unit No.	Complex Building Name	
Street No.	Street Name		
Suburb / District	City / Town		Post Code

* In the case of non-South African resident, the person responsible for the accounts residential address and contact telephone numbers in South Africa and country of origin must be provided, I, the undersigned, hereby confirms that Netcare may use the e-mail addresses as indicated in the patient / guarantor details for communication purposes on accounts and invoices.

Please tick ✓ the applicable box: Patient Person Responsible for Account
 Parent(s) or Guardian(s) - if minor child

 Full Name(s)

 Signature(s)

INJURY ON DUTY / WCA DETAILS

1. WCL2 AND WCL4 and certified ID document must be provided to the hospital.
2. Re-opening approval letter for case older than 2 years from date of accident must be provided to hospital.