

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 / Distr. t	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.