Capital Heart Endovascular Surgical

031 832 9700 / 031 832 9799
info@capitalsurgical.co.za
95 King Cetshwayo Highway or
44/46 Charles Henwood Westridge,
Durban 4001

HOSPITAL USE ONLY		
Doctor:	Surgery Booked Time:	Time of Arrival:
Ward Details:	Bed Details:	Pre-Admission Number:
Admission Date:	Surgery Booked Date:	Time:
Admitting Doctor:	Referring Doctor:	Alternate Doctor:
General GP:	ICD Code:	CPT Code:
Diagnosis:		
Procedure:		

PATIENT INFORMATION		
Identifier Type:	Identifier Number:	Preferred Method of Contact:
Surname:	Name:	Initials:
Title:	Gender:	Date of Birth:
Mobile Number:	Work Number:	Home Number:
Email Address:		
Residential Address: Suburb: City: Code:	Postal Address: Suburb: City: Code:	
Marital Status:	Dietry Preference:	Religion:
Congregation:	Minister:	

EMERGENCY CONTACT		
Surname:	Name:	Relationship to patient:
Work Number:	Mobile:	
Residential Address:		
Suburb:	City:	Code:

ALTERNATIVE CONTACT *[Person NOT living at the same address]*		
Surname:	Name:	Relationship to patient:
Work Number:	Mobile:	
Residential Address:		
Suburb:	City:	Code:

MEDICAL AID INFORMATION *[Please record as per medical aid card]*			
Medical Aid Scheme:		Plan:	Authorisation Number:
Principal member surname:		Name:	
Initials:	Title:	South African ID Number:	
Date of birth:		Gender:	Dependant Code:

GUARANTOR INFORMATION *[Person responsible for this account]*		
Identifier Type:	ID Number:	Title:
Surname:	Name:	Initials:
Gender:	Date of Birth:	Mobile:
Work Number:	Home Number:	Preferred Contact Method:
Email Address:		
Residential Address:		
Suburb:	City:	Code:

CLINICAL INFORMATION							
Please provide a brief description of the symptoms / complaints present when visiting the doctor:							
Should you be suffering from diabetes mellitus, please indicate which form of control is being practiced *[circle the appropriate option]:* Tablets Insulin Diet None							
Do you suffer from any of the following chronic conditions / illness? [Please indicate below]							
Hypertension	Multiple Sclerosis	Cholesterol	Emphysema	Asthma	Epilepsy	Thyroid Disorder	Lupus
Depression	Heart Failure	Porphyria	Other				

Patients please take note of the following:

1. **Private Patients** - A prepayment is required on hospitalisation from patients not covered by medical aid. It is suggested that private patients contact the accounts department prior to admission to establish the estimated hospital cost.
2. **Medical Aid Patients** - Please consult with your medical aid prior to admission obtaining pre-authorisation if necessary. Any short payments by your medical aid will be for your own account.
3. **Medical Aid card and ID Book** - Must be produced on admission otherwise patient will be treated as private.
4. **Private / Semi-Private Wards** - Medical aid patients requesting private wards will be expected to pay the private ward rate on admission.
   Please Note: Private wards are subject to availability.

I, ... hereby declare that the information I have provided is true and correct and agree to the terms and conditions as set out above.

Patient Signature .....

Date of Signature .....