Bariatric surgery application form

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

Who we are

Remedi Medical Aid Scheme is the medical scheme, registration number 1430, which is registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as "the administrator") is a separate company and an authorised financial services provider (registration number 1997/013480/07), which takes care of the administration of your membership of Remedi.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full.
3. Please fax this completed and signed form together with the required clinical information to **011 539 2704** or email **clinicalhelp@yourremedi.co.za**

1. Referring healthcare professional details (must be a surgeon, physician or endocrinologist)

Specialist name

Speciality

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

Email

Doctor's signature

Date D D M M Y Y Y Y

Name of facility the where the procedure will be done

BHF number of the facility where the procedure will be done

2. Details of the surgeon performing the procedure (if it differs from section 1)

Surgeon name

Specialist BHF number

Specialist HPCSA registration number

Telephone

Fax

Email

Doctor's signature

Date D D M M Y Y Y Y

3. Principal member information

Title

Initials

Surname

First name(s) (as per identity document)

ID or passport number

Membership number

Benefit option

Telephone (H)

Telephone (W)

Cellphone

Postal address (Post collected from post box, suite or private bag)

☐ PO Box	☐ Private Bag	Box number	
☐ Suite	☐ Postnet Suite	Number	
Suburb			
City		Postal code	
Telephone (H)		Telephone (W)	
Cellphone		Fax	

4. Patient information

Title		Initials	
Surname			
First name(s) (as per identity document)			
ID or passport number			
Telephone (H)		Telephone (W)	
Cellphone			
Email			

May we communicate your confidential information using the email address provided? Yes ☐ No ☐

May we communicate your confidential information using the fax number provided? Yes ☐ No ☐

5. Clinical history

1. Current weight in kilograms (kg)	
2. Height in centimetres (cm)	
3. Waist circumference in centimetres (cm)	
4. Body Mass Index (BMI)	
5. Blood pressure Systolic/Diastolic	/
6. Body fat %	% (only for patients <150 kg)

Co-morbid illnesses

1. Diabetes mellitus	☐
2. Hypertension	☐
3. Dyslipidaemia	☐
4. Coronary artery disease	☐
5. Other (specify)	☐

Please note: Attach script for the treatment of the above co-morbidities

What is the proposed surgical procedure?

Type of bariatric surgery:	Roux-en-Y	☐
	Bilopancreatic diversion (BPD)	☐
	Gastric sleeve	☐
	Gastric band	☐

Please attach the following to this application form

1. Report from endocrinologist/physician
2. Report from bariatric surgeon
3. Report from clinical psychologist/psychiatrist
4. Copy of blood results (eg fasting glucose, lipogram, TSH, ALT/GGT, CRP etc)
5. Copy of gastroscopy report
6. Report from biokineticist/physiotherapist (where applicable)
7. Sleep apnoea studies (where applicable)
8. Dietician report
9. Supporting documentation from an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure

6. Consent to collection of data for outcomes measurement and registry requirements

I, ______ (patient's name in full), hereby give Remedi consent to the collection of all medical/clinical information pertaining to my application for ______ (name of medication/procedure/test) for the treatment of ______ (name of condition) as requested either from myself or my consulting doctor, ______ (doctor's name in full). In addition I specifically consent to Remedi having access to my clinical records at my doctor's rooms for the purposes of conducting clinical audits.
The information will be used for the purposes of measuring clinical outcomes and developing a registry that will allow Remedi to make informed funding decisions.
The confidential nature of the information Remedi receives will be respected at all times.
I understand that approval for funding for this treatment is conditional upon my cooperation with all aspects of this pre-assessment.

Patient's signature ______

Date D D M M Y Y Y Y