THIS SHADED SECTION FOR OFFICE USE ONLY:

T 011 803 0016 F 011 803 6957 www.AIPA.co.za aipa@bellevy.co.za

ANAESTHETIC CONSENT FORM

Acc Message: .....

ANAESTHESIOLOGIST: ..... DATE: ..... Acc No: .....

Hospital Sticker

Designed by specialists
for specialists

CONSENT UPDATED BY:
BEL LEVY & ASSOCIATES (PTY) LTD

HOSPITAL ..... SURGEON .....

PROCEDURE: .....CODE .....

PREMED / Emrg / A LINE / CVP / PRONE / H&N / <1YR / <28D / PCA / ICU / BMI / BLOCK PL / BLOCK PR
W / T 0011 1215 1218 0032 0034 0043 0044 1221 1204 0018 2800 2802

ICD 10 How? ..... Weight: ..... Height: .....
Where?

BPC TIME 0039	THEATRE TIME 0023 0025
START..... h.....	START..... h.....
END..... h.....	END..... h.....
TOTAL.....	TOTAL.....

Sections A, B and C must be completed by the person responsible for the account.

NAME OF PATIENT : _____ TITLE : _____

DATE OF BIRTH : _____ ID No : _____

OCCUPATION : _____ AGE : _____

PARTICULARS OF PERSON RESPONSIBLE FOR PAYMENT OF THE ACCOUNT:

SURNAME : _____ TITLE : _____ SIGNATURE : _____

FULL NAMES : _____

OCCUPATION : _____ ID No : _____

RELATIONSHIP TO PATIENT : _____ LANGUAGE: _____

POSTAL ADDRESS : _____ HOME ADDRESS : _____

_____ _____

_____ CODE : _____ _____ CODE : _____

TEL No (H) : _____ TEL No (W) : _____ (FAX) : _____

E-MAIL: _____ (CELL) : _____

EMPLOYER'S or BUSINESS NAME : _____

BUSINESS ADDRESS : _____

_____ SPOUSE TEL No : _____

NAME OF MEDICAL AID : _____

MEMBER NAME : _____ Med Aid No : _____

PLAN : _____ AUTH No : _____

FAMILY MEMBER OR FRIEND NOT LIVING WITH YOU IN CASE OF EMERGENCY :

NAME : _____ TEL No (H) : _____ (W) : _____

Please sign on this side!

CONSENT FOR ANAESTHESIA AND AGREEMENT BETWEEN THE AIPA MEMBER WHO IS A SPECIALIST ANAESTHESIOLOGIST AND YOU THE PATIENT.
THIS FORM HAS BEEN COMPILED WITH THE SAFETY OF YOUR ANAESTHETIC IN MIND.

1. I confirm that I have been informed of the purpose of anaesthesia and I confirm that the risks and complications generally associated with anaesthesia have been explained to me. I have been afforded an opportunity to ask questions regarding my anaesthesia. I understand the anaesthetic options offered to me and have made my choice.
2. I understand that no one can guarentee an incident-free anaesthetic.
3. I understand that there is equipment and theatre staff supplied by the hospital which cannot be guaranteed by the anaesthesiologist. I exempt the anaesthesiologist from any adverse managed care requirements of my medical aid as required by the Health Professions Council of South Africa.
4. I agree to not drink alcohol, drive a car, or operate other dangerous equipment; make important decisions or sign contracts for 24 hours after recovery from anaesthesia. I understand that I may not consume alcohol while I am taking any medication prescribed to me by the anaesthesiologist.
5. I authorise the release of any clinical information, including my HIV status to any other member of the medical and paramedical profession responsible for my safety and treatment.
6. I agree to allow my personal data to be forwarded to the relevant organisations as required by law and to allow anonymous data of a clinical and practice management nature, to be collected to help improve the patient healthcare experience.
7. I understand that my anaesthetic will be administered by a Specialist Anaesthesiologist.

PAYMENT

1. The anaesthetic Account is rendered completely independently of the accounts rendered by the hospital and the surgeon.
2. I agree to pay the fee uniquely determined by the anaesthesiologist, estimated at .....; as required by the anti-competitive rules established by the Department of Trade and Industry for the Health Industry.
3. The fee is due and payable immediately on completion of the service. The account is rendered directly to you as required by the Medical Schemes Act No:131 of 1998.
4. I understand that I am personally responsible for payment and not my medical scheme. My medical scheme may not cover the full amount of the account, depending on the medical scheme and the plan option. I AM RESPONSIBLE FOR SUBMITTING THE ACCOUNT TO MY MEDICAL AID AND I UNDERTAKE TO SUBMIT THE ACCOUNT.
5. I agree that interest will be charged in accordance with the National Credit Act under incidental debt up to 2% per month on accounts that have not been settled. I understand that payments on outstanding accounts shall be allocated in the following way; interest, costs and then capital.
6. I also undertake to pay all legal, debt collection and tracing costs on the attorney and own client scale and charges as stipulated by the Debt Collectors Act 114 of 1998 relating to the recovery of fees outstanding on my account in respect of anaesthetic and other professional services rendered.
7. I consent to sharing information on my account with other credit grantors and with the credit bureau.
8. I confirm that the nominated postal address or e-mail address is correct for the purpose of receiving the account. I agree that should either of these addresses change, I will give one week's prior written notice for such change to become effective.
9. I hereby choose the nominated address as my DOMICILUM CITANDI ET EXECUTANDI for all purposes under this agreement and I agree that any notice sent to the nominated address by prepaid registered post or e-mail will be deemed to have been received by me on the third business day after the posting or sending of it. I further agree that any notice received by me by any means and at any address will be valid for all legal purposes notwithstanding that it was not sent by registered post or to my DOMICILUM CITANDI ET EXECUTANDI. I agree that should I wish to change my DOMICILUM CITANDI ET EXECUTANDI, I will give one week's prior written notice for such change to become effective.
10. There can be no unilateral changes to this agreement.

I have read and understood the contract. I confirm that the particulars furnished by me on all of the pages are in all respect s true and complete.

_____ _____ _____

SIGNATURE (Patient) **SIGNATURE (Guardian/Custodian)** **SIGNATURE (Specialist Anaesthesiologist)**

PLACE: _____ **DATE:** _____

WITNESS 1: _____ **WITNESS 2:** _____

All information is treated as confidential.

HAS THE PATIENT EVER HAD THE FOLLOWING:	Circle one	DETAILS
ALLERGY / unusual reaction to medicines/injections/food?	YES NO	
MEDICINES / PILLS Are you presently taking any? Specify	YES NO	
Including any homeopathic medicines? Specify	YES NO	
Have you taken any Aspirin in the last two weeks? If so, when?	YES NO	
Previous anaesthetics (if so, when and what operation)	YES NO	
Problems with previous anaesthetics (details please)	YES NO	
Any family member with anaesthetic problems (what?)	YES NO	
Porphyria, malignant hyperthermia or scoline apnoea	YES NO	
Cortisone Treatment in past 12 months	YES NO	
Heart disease (eg. Chest pain, heart attack, rheumatic fever)	YES NO	
High blood pressure	YES NO	
Asthma, bronchitus or emphysema	YES NO	
Recent cold, cough or flu	YES NO	
Diabetes or thyroid problems	YES NO	
Jaundice or hepatitis (If so, when?)	YES NO	
Kidney or bladder disease	YES NO	
Heartburn, hiatus hernia, peptic ulcer	YES NO	
Muscle weakness or auto immune illness	YES NO	
Epileptic convulsions / stroke or blackout of any sort	YES NO	
Tendency to bleed or bruise easily	YES NO	
False, loose, crowned or chipped teeth (if so, where?)	YES NO	
Do you have any infections at present?	YES NO	

Weight _____ Age _____ Height _____ Are you pregnant? (if so, how long?)

Do you smoke? (if so, how many per day?) Alcohol consumption: nil/social/moderate/heavy

When last did you eat _____ H _____ and drink fluids _____ H _____

Is there anything else you feel your anaesthesiologist should know?

Please sign overleaf!

Medical Billing Specialists
011-803-0016
QUANTUM REVENUE MANAGEMENT

Medical Billing Specialists
011-803-0016
QUANTUM REVENUE MANAGEMENT

O/E PRE-OP

BP PR
COLOUR TEMP
OED JVP
TEETH
H&N
A/W
CVS
RESP
GIT
OTHER
ASA
PREMED

SPECIAL INVESTIGATIONS

CXR
ECG
Hb WCC
INR PTT
Pit Bl. Gluc
Na K
Cl CO
U Cr

MONITORING

ECG		Ur Cath	
Oxim		NG Tube	
NIPB		Bld Warm	
CO_2		Ext Warm	
CVP		Temp	
Art			

VENTILATION S M

MASK ☐ HME ☐
LMA ☐ SIZE
ETT ☐ SIZE O / N
A/E ☐ CUFF ☐ PACK ☐
Circuit
Ventilator
V_E R
P_I V_T
$FI O_2$ PEEP

TIME TOTAL

DRUGS
1
2
3
4
5
6
7
8
9
10

GAS
FGF FiO_2(N_2O / Air)
H / I / S / D %

IV FLUIDS

220 F_1O_2
Vtxf
200 pH
pCO_2
180 pO_2
HCO_3
160 BE
Hb
140 K
120
100
80
60
40
SPO_2
Co_2
CVP
Dextrostix
Temp °c
Events (1) (2) Etc
Blood Loss
Urine Output

LINES (Type & Size) Site
1..... G .....
2..... G .....
3..... G .....
4.....

EVENTS & POST OP:

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Fax: 086 673 2341
Telephone: 011 796 6584/6771
Email: wilgpreadmission@lifehealthcare.co.za

Life HEALTH CARE Group

Impilo Patient information form

In case of a pre-admission please fax or hand in at pre-admissions ASAP - fax _____

Should you have any queries please contact reception for assistance on telephone _____

HOSPITAL USE ONLY		
DOCTOR:	**SURGERY BOOKED TIME:**	**TIME OF ARRIVAL:**
WARD DETAILS:	**BED DETAILS:**	**PRE-ADMISSION NUMBER:**

PATIENT INFORMATION			
PATIENT'S PERSONAL INFORMATION			
IDENTIFIER TYPE: ID NUMBER /PASSPORT NUMBER /PATIENT LIFE NUMBER		IDENTIFIER NUMBER:	
SURNAME:	NAME:		INITIALS:
OTHER NAMES:		KNOWN AS:	
TITLE : DR /FR /MISS /MR /MRS /MS /PROF /REV	GENDER: MALE / FEMALE	DATE OF BIRTH :	
MOBILE NUMBER: (000) 000 - 0000	WORK NUMBER:	HOME NUMBER:	
PREFERRED METHOD OF CONTACT? MOBILE / WORK / HOME / EMAIL	RECEIVE MARKETING? Y / N	RECEIVE STATEMENTS? Y / N	
EMAIL ADDRESS:			
RESIDENTIAL ADDRESS:		POSTAL ADDRESS:	
SUBURB:		SUBURB:	
CITY	CODE:	CITY	CODE:
MARITAL STATUS: SINGLE /MARRIED /DIVORCED	DIETARY PREFERENCE : FRUITARIAN / HALAAL / KOSHER / NONE / VEGAN / VEGETARIAN		
RELIGION:	CONGREGATION	MINISTER	
EMERGENCY CONTACT (PERSON TO BE CONTACTED IN CASE OF A MEDICAL EMERGENCY)			
SURNAME:	NAME:		
RELATIONSHIP TO PATIENT: CHILD / FRIEND / PARENT / GUARDIAN / RELATIVE / SIBLING / SPOUSE			
MOBILE NUMBER:	EMERGENCY CONTACT'S ADDRESS:		
WORK NUMBER:		SUBURB:	
HOME NUMBER:	CITY:		CODE:
ALTERNATIVE CONTACT: (PERSON NOT LIVING AT THE SAME ADDRESS)			
SURNAME:	NAME:		
RELATIONSHIP TO PATIENT: CHILD / FRIEND / PARENT / GUARDIAN / RELATIVE / SIBLING / SPOUSE			
MOBILE NUMBER:	ALTERNATIVE'S CONTACT'S ADDRESS:		
WORK NUMBER:		SUBURB:	
HOME NUMBER	CITY:		CODE:

PTO.../PAGE 2 CONTINUED

MEDICAL AID INFORMATION (PLEASE RECORD DETAILS AS PER MEDICAL AID CARD)

MEDICAL AID SCHEME:	PLAN:
MEMBER NUMBER:	AUTHORISATION NUMBER:
PRINCIPAL MEMBER SURNAME:	NAME
INITIALS: / TITLE : DR / FR / MISS / MR / MRS / MS / PROF / REV	SA ID NUMBER:
DATE OF BIRTH : / GENDER: MALE / FEMALE	DEPENDANT CODE:

HOSPITAL VISIT INFORMATION

ADMISSION DATE:	**SURGERY BOOKED DATE:**	**TIME:**
ADMITTING DOCTOR:	**REFERRING DOCTOR:**	
ALTERNATE DOCTOR:	**GENERAL GP:**	
ICD CODE / DIAGNOSIS:		
CPT CODE / PROCEDURE:		

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR THIS ACCOUNT)

IDENTIFIER TYPE: ID / PASSPORT / PATIENT LIFE NUMBER/NOT ASSIGNED	IDENTIFIER NUMBER:	
SURNAME:	NAME:	INITIALS:
OTHER NAMES:	KNOWN AS:	
TITLE : DR / FR / MISS / MR / MRS / MS / PROF / REV / GENDER: MALE / FEMALE	DATE OF BIRTH :	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:
PREFERRED METHOD OF CONTACT: MOBILE / WORK / HOME / EMAIL	RECEIVE MARKETING? Y / N	RECEIVE STATEMENTS? Y / N
EMAIL ADDRESS:		

RESIDENTIAL ADDRESS:	POSTAL ADDRESS:
SUBURB:	SUBURB:
CITY: / CODE:	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?	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** _____