ENROLMENT FORM
MATERNITY PROGRAMME

Eligibility code (for office use only)

GENERAL INFORMATION

TO BE COMPLETED BY THE EXPECTANT MOTHER

DETAILS OF PRINCIPAL MEMBER:

Membership number | Identity number

Surname

Title | Initials

Email address

DETAILS OF EXPECTANT MOTHER:

Surname

First name | Title

Address

Code

Email address

Telephone (H) (W)

(Cell) (Fax)

Preferred time of contact (Please tick)	**Day**	Monday	Tuesday	Wednesday	Thursday	Friday	
	Time	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00

Preferred method of contact (Please tick)

Telephonic ☐ Cell phone ☐ Home telephone ☐ Work telephone

Written ☐ Email ☐ Post ☐ Fax

DETAILS OF DOCTOR:

Surname | Initials

Practice number | Telephone

DETAILS OF GYNAECOLOGIST/MIDWIFE:

Name

Practice number | Telephone

Speciality

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TO BE COMPLETED BY THE EXPECTANT MOTHER (CONTINUED)

MEDICAL INFORMATION:

Weight kg Height cm

Smoking: Yes No Stopped <12 months ago >12 months ago

Exercise: Never <1 hour per week 1-3 hours per week >3 hours per week

Allergies: Penicillin Aspirin Sulphonamides

Other

PLEASE COMPLETE THE SECTION BELOW (OR REFER TO ATTENDING DOCTOR OR CAREGIVER)

PLEASE PROVIDE INFORMATION ON YOUR CURRENT PREGNANCY (if first child, only complete this section)

Are you currently being treated for any medical conditions, e.g. asthma, diabetes, HIV/AIDS, tuberculosis or depression? Yes No
If yes, please list the condition(s):

Do you consume alcohol? Yes No If yes, how often? More than 2 glasses per day Yes No

Expected delivery date D D M M Y Y Y Y First day of last menstrual period

PLEASE PROVIDE INFORMATION ON PREVIOUS PREGNANCIES

Number of pregnancies How many children do you have?

Do you have Twins? Yes No Triplets? Yes No

Have you previously experienced a miscarriage/stillbirth/an ectopic pregnancy? Yes No
If yes, please provide details:

Were any of your babies born with health problems, e.g. premature, spinal cord defects, congenital defects or late stillbirth? Yes No
If yes, please provide details (especially if the baby underwent surgery):

Have you previously had amniocentesis tests carried out? Yes No
If yes, please specify reason/s:

Were any of your babies born prematurely? Yes No Did you carry 2 weeks over term? Yes No

How were your children delivered? Vaginal birth Caesarean birth

Did you experience any of the following during a vaginal birth: Complications? Induced labour?
Vacuum extraction? (Delivery of baby with suction device)
Forceps-assisted birth? (delivery of baby with forceps)

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PLEASE PROVIDE INFORMATION ON PREVIOUS PREGNANCIES (CONTINUED)

Provide the reason for the caesarean birth (if applicable):

Elective (by choice) ☐

Other (please specify)

Did you experience any of the following during pregnancy:

☐ High blood pressure ☐ Diabetes ☐ Pre-eclampsia (High blood pressure with protein in the urine)

If any other problems were experienced, please specify.

Indicate if any of the following complications were experienced after the birth of your child.

☐ Placenta retention ☐ Postnatal depression ☐ Severe bleeding

☐ Breast problems ☐ Wound infection

Condition of baby(ies) after delivery:

☐ Breathing problems ☐ Neonatal jaundice (Yellowing of newborn's skin) ☐ Bleeding under scalp

☐ Paralysis (Unable to move one or more limbs) ☐ Other

Did you breastfeed your baby(ies)? ☐ Yes ☐ No If yes, for how long (weeks/months)?

PATIENT CONSENT

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that Metropolitan Health Risk Management (Pty) Ltd is the administrator of the Programme and that any medical treatment prescribed as well as the general management of my chronic condition(s) will be the sole responsibility of my medical practitioners, in consultation with me. Metropolitan Health Risk Management and my medical scheme and/or employer will accordingly not be held liable for any claims by me or my dependants arising from the implementation of the Programme.
3. I hereby give my consent to Metropolitan Health Risk Management, including their agents and medical staff to obtain my Special Personal Information (i.e. health and biometric) from my healthcare providers (pharmacy, pathology, medical doctor and radiology) to assess my medical risk and enrol me on the Programme and to use such information to my benefit. I understand and agree that Special Personal Information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
4. I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care.
5. I give my consent to Metropolitan Health Risk Management to electronically store, access, process and retain my Special Personal Information for the purposes set out in this document as may otherwise be required to administer the Programme.
6. Whilst Metropolitan Health Risk Management undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and/or employer and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Metropolitan Health Risk Management liable for any claims by me or my dependants arising from any unauthorised disclosure of my Special Personal Information to other parties.
7. I shall be entitled to terminate my participation in the Programme at any time with immediate effect on notice to my medical scheme, but understand that all benefits that I enjoyed under the Programme shall immediately cease and the scheme shall not be obliged to reinstate such benefits at any time thereafter. I understand that the consequences of such a decision will rest with me alone.

Continued overleaf »

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PATIENT CONSENT (CONTINUED)

8. I acknowledge that, should I not comply with the Programme protocols or prescribed treatment, my medical scheme and/or employer at its sole discretion may elect to exercise its rights and limit my benefits to the prescribed minimum benefits (PMBs), subject to the applicable legislation and the scheme rules.
9. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the Programme.
10. I understand and acknowledge that "consent", for the purposes of this document, means my informed consent, in other words:
    - 10.1 I have read and understood the contents of this document.
    - 10.2 I understand and acknowledge the nature and purpose for which the personal medical information that will be made available to and disclosed, used, processed and retained by my medical scheme and my healthcare providers, as set out in this consent.
    - 10.3 I have the legal capacity to give my informed consent, in other words, I am over the age of 18 and am able to fully understand and make decisions about my healthcare.

Patient's signature
(or signature of parent/guardian if patient is under age 18)

D D M M Y Y Y Y
Date

Membership no.

Doctor's practice no.

Return Address: Maternity Programme, PO Box 15079, Vlaeberg 8018
Fax 0861 222 552 **Email** bpmasdrm@metropolitanhrm.co.za