Registration Number 1506
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Medimed
Managing your healthcare security

MATERNITY PROGRAMME APPLICATION

A. IMPORTANT INFORMATION

1. **All information supplied on this form will be treated as confidential**
2. One application must be completed per beneficiary applying for enrolment per pregnancy.
3. Allow **5 working days** for the processing of your application.
4. Please submit all required information timeously, incomplete forms will not be processed.
5. Approval of enrolment is subject to the rules of the Scheme and Momentum TYB Clinical Protocols.
7. Send completed forms via fax **086 599 4511** or email **wellbeing@medimed.co.za** or call **0860103228** for more information

B. BENEFICIARY DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Tel) | Cellular

Email address

Residential Address

(if indicated maternity bag delivered by courier) | Code

The preferred method of communication is: Email | Telephone | Cellular | Post | Fax

C. BENEFICIARY MEDICAL HISTORY

Weight (kg) | Height (m) | Hip/Waist ratio | Smoker? Y N | Ave per day

Alcohol Y N | Units/week | Allergies Y N | Specify

Exercise: Type | Intensity (Tick) Low | Medium | High

Blood pressure (mmHg) | Blood Glucose (HGT) (mmol/L) | Chronic Authorisation

Chronic Conditions: Cardiovascular | Endocrine | Respiratory | Psychiatric | HIV | Other

D. CURRENT PREGNANCY

Last Menstrual Period (Y Y Y Y M M D D) | Expected Date of Delivery (Y Y Y Y M M D D)

Weeks Pregnant | Previous Pregnancies (including current pregnancy) | Number of live births

Is this a multiple pregnancy ? Y N | If yes, Twins | Triplets | Fertility Treatments? Y N

Have you had any antenatal scans? Y N | If yes, were any problems detected?

Are you currently suffering from any of the following pregnancy induced conditions?

Gestational Hypertension | Pre-Eclampsia | Gestational Diabetes | Placenta Previa

Mode of delivery (planned) Normal Vaginal Birth | Caesarian Section

E. PREVIOUS PREGNANCIES AND DELIVERIES

Have you ever had a multiple pregnancy? Y N | If yes, Twins | Triplets | Fertility Treatments? Y N

Have you previously had a miscarriage, stillbirth, ectopic pregnancy? Y N | If yes, please provide details:

Patient name _____ **Membership number** _____

E. PREVIOUS PREGNANCIES AND DELIVERIES

Have you previously had amniocentesis tests carried out? Y N If yes, please provide details _____

Did you experience any of the following during previous pregnancies? Small for gestational age ☐ Preterm labour ☐

Gestational Hypertension ☐ Pre-Eclampsia ☐ Gestational Diabetes ☐ Placenta Previa ☐

Previous deliveries? Vaginal birth Y N Number ☐ Caesarian Y N Number ☐

Did you experience any of the following during a vaginal birth? Induced labour ☐ Vacuum extraction ☐

Forceps ☐ Complications ☐ Please specify _____

Please provide reasons for the caesarian delivery: Elective caesarian ☐ Emergency caesarian ☐

Previous Caesar ☐ High Risk Pregnancy ☐ Other ☐ Please specify _____

Did you experience any of the following complications after the birth of your children? Placental retention ☐

Severe bleeding ☐ Post partum infection ☐ Breast feeding problems ☐ Post natal depression ☐

G. PREVIOUS NEONATAL COMPLICATIONS

Did your newborn babies experience any health problems Y N If yes, please specify Preterm ☐ Gestation ☐

Breathing problems ☐ Neo-natal jaundice ☐ Bleeding under scalp ☐ Feeding problems ☐

Other ☐ Please specify _____

H. MEDICAL PRACTITIONER DETAILS

General Practioner: Surname _____ Initials ☐☐ Practice no. ☐☐☐☐☐☐☐☐

Telephone number ☐☐☐☐☐☐☐☐☐☐☐☐ Fax number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Gynae/Obstetrician: Surname _____ Initials ☐☐ Practice no. ☐☐☐☐☐☐☐☐

Telephone number ☐☐☐☐☐☐☐☐☐☐☐☐ Fax number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Midwife: Surname _____ Initials ☐☐ Practice no. ☐☐☐☐☐☐☐☐

Telephone number ☐☐☐☐☐☐☐☐☐☐☐☐ Fax number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Enrolment form completed by: Name _____ Designation _____

Signature _____ Date Y Y Y Y M M D D

I. DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the Wellbeing Team;
- All information concerning this application will remain confidential at all times.
- I accept that I have a responsibility towards my own health and that of my unborn child, irrespective of the maternity programme
- All treatment decisions remain the responsibility of the of the beneficiary's health care provider irrespective of the application decision made in terms of the Scheme rules, clinical criteria and protocols.

Expectant mother's signature (or gaurdian) _____ Date Y Y Y Y M M D D

J. ADMINISTRATION USE ONLY

Did the member receive a maternity bag? Y N Who issued the maternity bag _____

Was information given regarding the maternity programme? Y N Was information given regarding benefits Y N

NOTES