Pre- Authourisation Hospital Form

Patients's Details

First Name (s) : Surname :

Medical aid option : Membership No :

Date of Birth : Cell No. :

Home Contact : Work No. :

Additional Contact: Email :

Doctor's Details

First Name (s) : Surname :

Contact No. : Practicing No :

Email:

Hospital Name:

Diagnosis/ Reason for Hospitalisation:

Procedure and Codes:

Medical History /Treatment Plan:

Investigations Done:

Date of Admission: Estimated Length of Stay:

*Costs / quote required

Acknowledgement by Examinating Doctor

I certify that the particulars hereto are - to the best of my knowledge and belief - true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

Signature of Medical Practitioner

Date

Place QR code/barcode or Stamp