PRE-ADMISSION FORM

Pre-Auth No / Auth No: _____

1. Details of Medical Aid Main Member:

Title: _____ Surname: _____ Full Names: _____

I D Number: _____ DOB _____ Gender: M / F

Cell No: _____ Employer: _____

Tel No (H) _____ (W) _____ Occupation: _____

Postal Address: _____ E-mail address: _____

_____ Medical Aid: _____ Plan: _____

_____ Postal Code: _____ Member No: _____

2. Details of Patient:

Title: _____ Surname: _____ Full Names: _____ Marital Status: _____

I D Number: _____ DOB _____ Gender: M / F

Cell No: _____ Employer: _____

Tel No (H) _____ (W) _____ Occupation: _____

Relationship to Main Member: _____ Dep Code: _____ E-mail address: _____

Residential Address: _____ Vehicle Details (If staying at Vista): Make/Model/Colour _____

_____ _____

_____ Postal Code: _____ Registration No: _____

Do you have a fire-arm OR other weapon (ie pocket knife) with you? Y / N If yes, please hand in at police / give to a family member before admission.

3. Next of Kin NOT living with you:

Name and Surname: _____ Relationship: _____

Residential address: _____ Cell No: _____

_____ Tel No (H) _____ (W) _____

_____ Postal Code: _____

4. Who can we contact in an emergency:

Name and Surname: _____ Relationship _____

Tel No (H) _____ (W) _____ Cell No: _____

Note: If transport cannot be arranged, we have transport / taxi service available - costs to be covered by yourself

5. Psychiatric treatment information and history:

Referring Doctor's Name: _____ Diagnosis code: _____

Tel No: _____ Any chronic illnesses? _____

5.1 Previous Psychiatric Treatment:

Hospitalisation as in-patient (Vista) Date: _____ No of Days: _____

5.2 Other treatment received: Facility / Doctor / Psychologist:

Name: _____ Date / s: _____

Name: _____ Date / s: _____

Note: ***Any / all of the above may affect your current benefits***

6. I hereby declare that the information quoted above (main member and patient), is true and correct.

Patient Signature: _____ Main Member/Guardian Signature: _____

Date: _____ Date: _____