

Eligibility code
(for office use only)

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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?

 Y N

If yes, please list the condition(s):

Do you consume alcohol?

 Y N

If yes, how often? More than 2 glasses per day

 Y N

Expected delivery date

D	D	M	M	Y	Y	Y	Y
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First day of last menstrual period

D	D	M	M	Y	Y	Y	Y
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PLEASE PROVIDE INFORMATION ON PREVIOUS PREGNANCIES

Number of pregnancies

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How many children do you have?

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Do you have

Twins?

 Y N

Triplets?

 Y N

Have you previously experienced a miscarriage/stillbirth/an ectopic pregnancy?

 Y N

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?

 Y N

If yes, please provide details (especially if the baby underwent surgery):

Have you previously had amniocentesis tests carried out?

 Y N

If yes, please specify reason/s:

Were any of your babies born prematurely?

 Y N

Did you carry 2 weeks over term?

 Y N

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?

Forceps-assisted birth?

(Delivery of baby with suction device)

(delivery of baby with forceps)

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

Elective (by choice)

Other (please specify)

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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.

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Placenta retention | <input type="checkbox"/> Postnatal depression | <input type="checkbox"/> Severe bleeding |
| <input type="checkbox"/> Breast problems | <input type="checkbox"/> Wound infection | |

Condition of baby(ies) after delivery:

- | | | |
|--|---|---|
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Neonatal jaundice
(Yellowing of newborn's skin) | <input type="checkbox"/> Bleeding under scalp |
| <input type="checkbox"/> Paralysis
(Unable to move one or more limbs) | <input type="checkbox"/> Other | |

Did you breastfeed your baby(ies)?

<input type="checkbox"/> Y	<input type="checkbox"/> N
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If yes, for how long (weeks/months)?

I hereby acknowledge that the scheme has appointed Qualsa Healthcare (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner.

I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.

Whilst Qualsa undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Qualsa liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

Please fax the completed form to 0861 888 113.

Should you have any queries, please contact Transmed on 0800 225 151, or send an e-mail to transmedtreatment@qualsa.co.za