

Contact us

Tel: 0800 226 5633 (0800 BANKMED) • Private Bag X2, Rivonia, 2128 • www.bankmed.co.za

## **Bariatric surgery application form**

This application form is to apply for funding for bariatric surgery. It must be completed by a accredited surgeon from an accredited centre of excellence who will be performing the surgery. The member must complete sections 3, 4 and 6 of this form.

The turnaround time on receipt of a completed form is seven working days. We may require an additional three days should we need to forward the request to an external advisory panel before reaching a funding decision.

## How to complete this form

- 1. Please use one letter per block, complete with black ink and print clearly
- 2. To avoid administration delays, please ensure this application is completed in full
- 3. Send the completed and signed form with the required clinical information and patient consent to us via e-mail at motivations@bankmed.co.za

1. Referring healthcare professional details (must be a surgeon, physician or endocrinological details)	gist	t)										
Specialist name												
Speciality												
Specialist BHF number Specialist HPCSA registration num	ber											
Telephone Elephone	F	ax										
E-mail address												
Doctor's signature			Di	ate	Υ	Υ	Υ	Υ	M	M	D	D
Name of facility where the procedure will be done												
BHF number of the facility where the procedure will be done												
2. Details of the surgeon performing the procedure (if it differs from section 1)												
Surgeon name												
Specialist BHF number Specialist HPCSA registration num	ber											
Telephone Elliphone	F	ax										
E-mail address												
Doctor's signature			Da	ate	Υ	Υ	Υ	Υ	M	M	D	D
3. Main member information												
Title Initials Surname												
First name/s (as per identity document)												
Date of birth Y Y Y M M D D ID or passport number												
Bankmed membership number												
Bankmed plan type												
Postal address Oostal address												
							Со	de				
Felephone (H)	(W	/)										
Cellphone	Fa	Х										

Bankmed Medical Scheme. Registration number 1279.

4. Patient information	
Title Initials	Surname Surname
First name	Sex M F Date of birth Y Y Y M M D
Telephone (H)	(w)
Cellphone	Fax
E-mail address	
	dential information using the e-mail address provided? Yes No
May we communicate your confi	dential information using the fax number provided?  Yes  No  No
5. Clinical history	
1. Current weight in kilograms (	kg)
2. Height in centimetres (cm)	
3. Waist circumference in centir	metres (cm)
4. Body Mass Index (BMI)	
5. Blood pressure Systolic/Diast	tolic / /
6. Body fat %	% (only for patients <150kg)
Co-morbid illnesses	
1. Diabetes mellitus	
2. Hypertension	
3. Dyslipidaemia	
5. Coronary artery disease	
6. Other (specify)	
Please note: Attach script for the	e treatment of the above co-morbidities
What is the proposed surgical p	procedure?
Type of bariatric surgery:	Roux-en-Y
7,500	Bilopancreatic diversion (BPD)
	Gastric sleeve
	Gastric band
Please attach the following to the	his application form
Report from endocrinologist/	
2. Report from bariatric surgeor	
3. Report from clinical psychological psycho	gist/psychiatrist
4. Copy of blood results (eg fast	ing glucose, lipogram, TSH, ALT/GGT, CRP etc)
5. Copy of gastroscopy report	
6. Report from biokineticist/phy	
7. Sleep apnoea studies (where	applicable)
8. Dietician report	an an anaethetict verifying that the national is modically fit to undergo an anaethetic procedure
9. Supporting documentation in	om an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure
6. Consent to collection o	f data for outcomes measurement and registry requirements
medication/procedure/test) for t as requested either from myself on name in full). In addition I specific	(patient's name in full), hereby give Bankmed Medical Scheme and Discovery Health (Pty) Ltd edical/clinical information pertaining to my application for(name of he treatment of(name of condition or my consulting doctor,
outcomes and developing a regist the information Bankmed Medica	try that will allow Bankmed Medical Scheme to make informed funding decisions. The confidential nature of all Scheme and Discovery Health (Pty) Ltd receives will be respected at all times. I understand that approval for ditional upon my cooperation with all aspects of this pre-assessment.

Date

Patient's signature