

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 by e-mail at motivations@bankmed.co.za

1. Referring Healthcare Professional details (must be a surgeon, physician or endocrinologist)

Specialist name	<input type="text"/>																		
Speciality	<input type="text"/>																		
Specialist BHF number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Specialist HPCSA registration number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
E-mail address	<input type="text"/>																		
Healthcare Professional's signature	<input type="text"/>										Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Name of facility where the procedure will be done	<input type="text"/>																		
BHF number of the facility where the procedure will be done	<input type="text"/>																		

2. Details of the surgeon performing the procedure (if it differs from section 1)

Surgeon name	<input type="text"/>																	
Specialist BHF number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Specialist HPCSA registration number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
Telephone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>						
E-mail address	<input type="text"/>																	
Healthcare Professional's Signature	<input type="text"/>										Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Principal Member information

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>												
First name/s (as per identity document)	<input type="text"/>																
Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	ID or passport number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Bankmed membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Bankmed Plan type	<input type="text"/>			
Postal address	<input type="text"/>										Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		

4. Patient information

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
First name	<input type="text"/>	Sex	<input type="text"/> M <input type="text"/> F	Date of birth	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>	Fax	<input type="text"/>
Cellphone	<input type="text"/>				
E-mail address	<input type="text"/>				

May we communicate your confidential information using the e-mail address provided?

Yes No

May we communicate your confidential information using the fax address provided?

Yes No

5. Clinical history

1. Current weight in kilograms (kg)	<input type="text"/>
2. Height in centimetres (cm)	<input type="text"/>
3. Waist circumference in centimetres (cm)	<input type="text"/>
4. Body Mass Index (BMI)	<input type="text"/>
5. Blood pressure Systolic/Diastolic	/
6. Body fat %	% (only for patients <150 kg)

Co-morbid illnesses

1. Diabetes mellitus	<input type="checkbox"/>
2. Hypertension	<input type="checkbox"/>
3. Dyslipidaemia	<input type="checkbox"/>
4. Coronary artery disease	<input type="checkbox"/>
5. Other (specify)	<input type="checkbox"/>

Please note: Attach script for the treatment of the above co-morbidities

What is the proposed surgical procedure?

Type of bariatric surgery:	Roux-en-Y	<input type="checkbox"/>
	Bilopancreatic diversion (BPD)	<input type="checkbox"/>
	Gastric sleeve	<input type="checkbox"/>
	Gastric band	<input type="checkbox"/>

Please attach the following to this application form

1. Report from endocrinologist/physician
2. Report from bariatric surgeon
3. Report from clinical psychologist/psychiatrist
4. Copy of blood results (eg fasting glucose, lipogram, TSH, ALT/GGT, CRP etc)
5. Copy of gastroscopy report
6. Report from biokineticist/physiotherapist (where applicable)
7. Sleep apnoea studies (where applicable)
8. Dietician report
9. Supporting documentation from an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure

6. Consent to collection of data for outcomes measurement and registry requirements

I, (patient's name in full), hereby give Bankmed Medical Scheme and Discovery Health (Pty) Ltd consent to the collection of all medical/clinical information pertaining to my application for (name of medication/procedure/test) for the treatment of (name of condition) as requested either from myself or my consulting Healthcare Professional (Healthcare Professional's in full). In addition I specifically consent to Bankmed Medical Scheme and Discovery Health (Pty) Ltd having access to my clinical records at my Healthcare Professional's rooms for the purposes of conducting clinical audits. The information will be used for the purposes of measuring clinical outcomes and developing a registry that will allow Bankmed Medical Scheme to make informed funding decisions. The confidential nature of the information Bankmed Medical Scheme and Discovery Health (Pty) Ltd receives will be respected at all times. I understand that approval for funding for this treatment is conditional upon my cooperation with all aspects of this pre-assessment.

Patient's signature

If patient is a minor, Principal Member to sign

Date

Y	Y	Y	Y	M	M	D	D
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Up to date forms are always available on www.bankmed.co.za