

Bariatric surgery application form

Purpose of this form

This application form is to apply for funding for bariatric surgery. It must be completed by an 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 need an additional three days if we need to send the request to an external advisory panel before we reach a funding decision.

How to complete this form

1. Please use one letter per block, complete with black ink and print clearly or complete the form digitally.
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 to **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"/>	<input type="text"/>	<input type="text"/>	Specialist HPCSA registration number	<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"/>	<input type="text"/>	<input type="text"/>	Fax	<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 the 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"/>	<input type="text"/>	<input type="text"/>	Specialist HPCSA registration number	<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"/>	<input type="text"/>	<input type="text"/>	Fax	<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 details

ID or passport 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"/>
Name	<input type="text"/>											
Surname	<input type="text"/>											

4. Patient details

Title	<input type="text"/>	Initial(s)	<input type="text"/>
First name(s)	<input type="text"/>		
Surname	<input type="text"/>		
Membership number	<input type="text"/>		
ID or passport number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<input type="text"/>		<input type="text"/>
E-mail	<input type="text"/>		
Relationship to Principal Member	<input type="text"/>		

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	<input type="text"/> / <input type="text"/>
6. Body fat %	<input type="text"/> % (only for patients <150 kg)

Comorbid 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 comorbidities

What is the proposed surgical procedure?

Type of bariatric surgery:	Roux-en-Y	<input type="checkbox"/>
	Biliopancreatic 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 (e.g. 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 for collection of data for outcomes measurement and registry requirements

I, (patient's name in full), hereby give Bankmed consent for 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 by myself or my consulting Healthcare Professional (Healthcare Professional's name in full). In addition, I specifically consent to Bankmed 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 to make informed funding decisions. The confidential nature of the information Bankmed receives will be respected at all times. I understand that approval for funding for this treatment is confidential upon my cooperation with all aspects of this pre-assessment.

Patient's signature

Date

Y	Y	Y	Y	M	M	D	D
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Benefit only available for members over 18 years of age

*Up to date forms are always available on www.bankmed.co.za