PROVIDENCE
Healthcare Risk Managers

MATERNITY PROGRAMME APPLICATION

A. IMPORTANT INFORMATION

1. **All information supplied on this form will be treated as confidential**
2. One application must be completed per beneficiary applying for enrolment per pregnancy.
3. Allow **5 working days** for the processing of your application.
4. Please submit all required information timeously, incomplete forms will not be processed.
5. Approval of enrolment is subject to the rules of the Scheme and PROVIDENCE Clinical Protocols.
6. You may contact the WellbeingTeam at **0860103228** or email **wellbeing@providence.co.za**
7. Send completed forms via fax **086 599 4511** or email **wellbeing@providence.co.za**

B. BENEFICIARY DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number (Home) | (Work)

Fax number | Cellular

Email address

Residential Address

(if indicated maternity bag delivered by courier) | Code

The preferred method of communication is: Email ☐ Telephone ☐ Cellular ☐ Post ☐ Fax ☐

C. BENEFICIARY MEDICAL HISTORY

Weight kg | Height m | Hip/Waist ratio | Smoker? Y N | Ave per day

Alcohol Y N | Units/week | Allergies Y N | Specify

Exercise: Frequency X per week | Type | Intensity (Tick) Low ☐ Medium ☐ High ☐

Current blood pressure mmHg | Pulse /m | Blood Glucose (HGT) mmol/L

Chronic Conditions: Cardiovascular ☐ Endocrine ☐ Respiratory ☐ Psychiatric ☐ HIV ☐ Other ☐

Please specify | Chronic Authorisation **IHC**

D. CURRENT PREGNANCY

Last Menstrual Period (Y Y Y Y M M D D) | Expected Date of Delivery (Y Y Y Y M M D D)

Weeks Pregnant | Previous Pregnancies (including current pregnancy) | Number of live births

Is this a multiple pregnancy ? Y N | If yes, Twins ☐ Triplets ☐ | Fertility Treatments? Y N

Have you had any antenatal scans? Y N | If yes, were any problems detected?

Are you currently suffering from any of the following pregnancy induced conditions?

Gestational Hypertension ☐ Pre-Eclampsia ☐ Gestational Diabetes ☐ Placenta Previa ☐

Mode of delivery (planned) Normal Vaginal Birth ☐ Caesarian Section ☐ If yes, please select indication

Elective Caesarian ☐ Previous Caesar ☐ Multipe Births ☐ High Risk Pregnancy ☐

E. PREVIOUS PREGNANCIES

Have you ever had a multiple pregnancy? Y N | If yes, Twins ☐ Triplets ☐ | Fertility Treatments? Y N

Have you previously had a miscarriage, stillbirth, ectopic pregnancy? Y N | If yes, please provide details:

Have you previously had amniocentesis tests carried out? Y N | If yes, please provide details

Did you experience any of the following during previous pregnancies? Small for gestational age ☐ Preterm labour ☐

Gestational Hypertension ☐ Pre-Eclampsia ☐ Gestational Diabetes ☐ Placenta Previa ☐

Patient name

Membership number

F. PREVIOUS DELIVERIES

Previous deliveries? Vaginal birth Y N Number Caesarian Y N Number

Did you experience any of the following during a vaginal birth? Induced labour Vacuum extraction

Forceps Complications Please specify

Please provide reasons for the caesarian delivery: Elective caesarian Emergency caesarian

Previous Caesar High Risk Pregnancy Other Please specify

Did you experience any of the following complications after the birth of your children? Placental retention

Severe bleeding Post partum infection Breast feeding problems Post natal depression

G. PREVIOUS NEONATAL COMPLICATIONS

Did your newborn babies experience any health problems Y N If yes, please specify Preterm Gestation

Breathing problems Neo-natal jaundice Bleeding under scalp Feeding problems

Other Please specify

H. MEDICAL PRACTITIONER DETAILS

General Practioner: Surname Initials Practice no.

Telephone number Fax number

Gynae/Obstetrician: Surname Initials Practice no.

Telephone number Fax number

Midwife: Surname Initials Practice no.

Telephone number Fax number

Enrolment form completed by: Name Designation

Signature Date Y Y Y Y M M D D

I. DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the Wellbeing Team;
- It may be a pre-condition to the approval of the Maternity Benefit that I register and comply with the requirements of a Disease Management Programme and that non-compliance may lead to the withdrawal of this benefit;
- All information concerning this application will remain confidential at all times.
- I accept that I have a responsibility towards my own health and that of my unborn child, irrespective of the maternity programme
- All treatment decisions remain the responsibility of the of the beneficiary's health care provider irrespective of the application decision made in terms of the Scheme rules, clinical criteria and protocols.

Expectant mother's signature (or gaurdian) Date Y Y Y Y M M D D

J. ADMINISTRATION USE ONLY

Did the member receive a maternity bag? Y N Who issued the maternity bag

Was information given regarding the maternity programme? Y N Was information given regarding benefits Y N

NOTES