Ahmed Al-Kadi Private Hospital Ltd
486-490 King Cetshwayo Highway, Mayville, Durban, 4091
27 31 492 3400
info@aakh.co.za

Pre-Admission Form

Please email or hand in at pre-admissions ASAP - email: admissions@aakh.co.za
Should you have any queries please contact reception for assistance on telephone 031 492 3400

PATIENT INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
ID NUMBER:		DATE OF BIRTH:	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			
ALLERGIES:	RELIGION:	LANGUAGE:	
RESIDENTIAL ADDRESS:			
		POSTAL CODE:	
POSTAL ADDRESS:			
		POSTAL CODE:	

MEDICAL AID DETAILS	
MEDICAL AID NAME:	PLAN:
MEMBER NUMBER:	DEPENDANT CODE OF PATIENT:
PRINCIPAL MEMBER SURNAME:	NAME:
PRINCIPAL MEMBER ID NUMBER:	DATE OF BIRTH:

HOSPITAL VISIT INFORMATION	
ADMISSION DATE:	SURGERY DATE:
ADMITTING DOCTOR:	
ICD CODE / DIAGNOSIS:	
CPT CODE / PROCEDURE:	
NRPL CODE:	

HOSPITAL USE ONLY
PRE-ADMISSION NUMBER:
MEDICAL AID AUTHORISATION NUMBER:
CO-PAYMENT / DEDUCTIBLE:

GUARANTOR INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
ID NUMBER:		DATE OF BIRTH:	
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			

EMERGENCY CONTACT INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
RELATIONSHIP TO PATIENT:			
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			
RESIDENTIAL ADDRESS:			
		POSTAL CODE:	

ALTERNATE CONTACT INFORMATION			
TITLE:	INITIALS:	SURNAME:	
FIRST NAME/S:			
RELATIONSHIP TO PATIENT:			
MOBILE NUMBER:	WORK NUMBER:	HOME NUMBER:	
EMAIL ADDRESS:			

DOCUMENTS REQUIRED ON ADMISSION	
§ ORIGINAL MEDICAL AID CARD	
§ PATIENT ID	
§ MAIN MEMBER / GUARANTOR ID	

PLEASE TAKE NOTE OF THE FOLLOWING:

PRIVATE PATIENTS - A DEPOSIT IS REQUIRED ON ADMISSION AS PER THE ESTIMATED QUOTATION PROVIDED.

MEDICAL AID PATIENTS - PLEASE SECURE AN AUTHORISATION NUMBER FROM YOUR MEDICAL AID PRIOR TO ADMISSION AS WELL AS CONFIRM ANY CO-PAYMENTS/DEDUCTIBLES. ANY SHORT PAYMENTS BY YOUR MEDICAL AID WILL BE FOR YOUR OWN ACCOUNT.

PRIVATE WARD REQUESTS - AVAILABLE ON REQUEST SHOULD THE ROOM BE AVAILABLE. PRIVATE WARD RATE PAYABLE ON ADMISSION.

I HEREBY CONFIRM THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND CORRECT AND AGREE TO THE TERMS AND CONDITIONS AS SET OUT ABOVE.

PATIENT SIGNATURE: _____ DATE: _____