# ADMISSION FORM / OPNAME VORM

UROLOCARE HOSPITALS
(Pty) Ltd. Reg. No/nr. 2001/005764/07
THE UROLOGY HOSPITAL

Practice No./ Praktyk Nr. 5808847

**Postal Address / Posadres**
P.O. Box / Posbus 13271
Hatfield
0028

**Telephone / Telefoon**
(012) 423-4000
Fax / Faks: (012) 342-9517
Fax / Faks: (012) 342-1233

**Verseker asseblief dat u vooraf goedkeuring het van u mediese fonds.**
**Please make sure that you obtain pre-authorisation from your medical aid.**

Date of admission / Opname datum: ..... Time of admission / Tyd opgeneem: .....

Referring Doctor / Verwys deur Dr: ..... Urologist / Uroloog: Dr. .....

**Patient Details / Pasiënt Besonderhede**

Title / Titel: ..... Blood Transfusion / Bloed Oortapping ( √ / x )

Names / Name: ..... Bloodgroup / Bloedgroep: .....

Surname / Van: ..... .....

ID Nr. / ID No: ..... Passport No. / Paspoort Nr: .....

Gender / Geslag: ..... Date of Birth / Geboorte Datum: .....

Language / Taal: ..... Religion / Geloof: .....

Allergy / Allergië: ..... .....

Nationality / Nasionaliteit: ..... .....

Occupation / Beroep: ..... Ethnic Group / Etnise Groep: .....

Residential Address / Woonadres: ..... .....

..... Postal Code / Poskode: .....

Postal Address / Posadres: ..... .....

..... Postal Code / Poskode: .....

Cell No. / Selfoon Nr: .....

Home Tel. No. / Huis Tel. Nr: ..... Work Tel. No. / Werk Tel. Nr: .....

**Employer Details / Werkgewer Besonderhede**

Employer Name / Werkgewer: ..... .....

Address / Adres: ..... .....

..... Postal Code / Poskode: .....

Contact No. / Kontak Nr. .....

**Next of Kin / Naasbestaande (Not living with you / Wat nie by u woon nie)**

Name and Surname / Naam en Van: ..... .....

Address / Adres: ..... .....

..... .....

Postal Code / Poskode: ..... Home Tel. No. / Huis Tel Nr: .....

Work Tel No. / Werk Tel. Nr: ..... Cell No. / Selfoon Nr: .....

**Contact Person / Kontak Persoon (in Case of Emergency / in Geval van Nood)**

Name and Surname / Naam en Van: .....

Contact No. / Kontak Nr: .....

**Medical Aid Details / Mediese Fonds Besonderhede:**

Medical Aid Name / Mediese Fonds Naam: .....

Option / Opsie: .....

Member Number / Lidnommer: .....

Dependant Code / Afhanklike Kode: .....

**Person Responsible for Account / Persoon Verantwoordelik vir Rekening (Main Member Details / Hooflid Besonderhede)**

Surname / Van: ..... E-mail / E-pos .....

Full Names / Volle Name: .....

Title / Titel: ..... Initials / Voorletters: .....

Home Tel. No. / Huis Tel. Nr: ..... Work Tel. No. / Werk Tel. Nr: .....

Cell No. / Selfoon Nr: ..... Fax No. / Faks Nr: .....

Occupation / Beroep: .....

Residential Address / Woonadres: .....

..... Postal Code / Poskode: .....

Postal Address / Posadres: .....

..... Postal Code / Poskode: .....

Member ID No. / Hooflid ID Nr: .....

Beneficiary Relationship / Afhanklike Verwantskap: .....

**Injury on Duty Details / Besering aan Diens Besonderhede:**

Date of Injury / Datum van Besering: ..... Time of Injury / Tyd van besering: .....

Claim Number / Eisnommer: .....

Employer Reg. No. / Werkgewer Reg. Nr: .....

Employer VAT No. / Werkgewer BTW Nr: .....

Employer E-Mail / Werkgewer E-Pos .....

**Declaration / Verklaring:**

I, the undersigned, acknowledge that the abovementioned details are correct.

Ek, die ondergetekende, erken hiermee dat die bostaande inligting korrek is.

.....

Signature (Member, Spouse, Next of Kin, Guarantor)
Handtekening (Hooflid, Eggenoot, Naasbestaande, Borg)