Bariatric surgery application form 2024

Discovery Health Medical Scheme

Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, **www.discovery.co.za**, PO Box 784262, Sandton, 2146,
1 Discovery Place, Sandton, 2196.

Purpose of the 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

- Fill in the form in black ink and print clearly, or complete the form digitally by using Adobe Acrobat Reader.
- To avoid administration delays, please ensure this application is completed in full.
- Send the completed and signed form with the required clinical information and patient consent to us by email at **motivations@discovery.co.za** or get help on **www.discovery.co.za** under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

1. Referring healthcare professional details (must be a surgeon, physician or endocrinologist)

Title | Initials

Surname

First name(s) (as per identity document)

Speciality

Specialist BHF number | Specialist HPCSA registration number

Telephone (H) | Telephone (W)

Cellphone

Email

Doctor's signature | Date D D M M Y Y Y Y

Name of facility where the procedure will be done

BHF number of the facility where the procedure will be done

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

Title | Initials

Surname

First name(s) (as per identity document)

Speciality

Specialist BHF number | Specialist HPCSA registration number

Telephone (H) Telephone (W)

Cellphone

Email

Doctor's signature Date D D M M Y Y Y Y

3. Main member details

Membership number

ID or passport number

Member’s name

Member’s surname

4. Patient details

Title Initials

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) Telephone (W)

Cellphone

Relationship to main member

5. Clinical history

1. Current weight in kilograms (kg)

2. Height in centimetres (cm)

3. Waist circumference in centimetres (cm)

4. Body Mass Index (BMI)

5. Blood pressure systolic/diastolic

6. Body fat % (only for patients <150kg)

Co-morbid illnesses

1. Diabetes mellitus ☐
2. Hypertension ☐
3. Dyslipidaemia ☐
4. Coronary artery disease ☐
5. Other (specify)

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 ☐ Bilopancreatic diversion (BPD) ☐
Gastric sleeve ☐ Gastric band ☐

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. Dietitian report
9. Supporting documentation from an anaesthetist 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 Discovery Health Medical Scheme and Discovery Health (Pty) Ltd consent to the collection of all medical/clinical information pertaining to my application for _____ (name of condition) as requested either from myself or my consulting doctor, _____ (doctor's name in full)

In addition I specifically consent to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd having access to my clinical records at my doctor'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 Discovery Health Medical Scheme to make informed funding decisions. The confidential nature of the information Discovery Health 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 me cooperating with all aspects of this pre-assessment.

Patient's signature _____ Date D D M M Y Y Y Y