Reg. No.:1013
7 Lutman Street
Richmond Hill | Port Elizabeth | 6001
P.O. Box 1672 | Port Elizabeth | 6000
Customer Care: 0860 123 4567

MATERNITY PROGRAMME APPLICATION

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 Momentum TYB Clinical Protocols.
6. You may contact the WellbeingTeam at **0860103228** or email **wellbeing@rumed.co.za**
7. Send completed forms via fax **086 599 4511** or email **wellbeing@rumed.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 ☐

Accredited by: SABS ISO 9001

Administered by: momentum TYB

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Patient name

Membership number

E. PREVIOUS PREGNANCY

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 ☐

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 PRACTIONER 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

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