Dr Hina Neurosurgery Inc
Dr. Thembani S. Hina
SPECIALIST NEUROSURGEON, ENDOVASCULAR SUBSPECIALIST
Practice Number: 128 1259

Reception: Admin@drhinaneuro.com
021 441 0567 / 021 441 0568
Suite 204, The Link Building,
Netcare Christiaan Barnard Memorial Hospital,
11 DF Malan Street, Foreshore, Cape Town, 8001

PRE-ADMISSION FORM

Please complete in BLOCK LETTERS (or type into the fields) and return to reception before your admission date.

1. ADMISSION DETAILS (PRACTICE USE)

Admission date	Admission time	Procedure / surgery date	Hospital

Ward / unit	Planned procedure

ICD-10 code(s)	Procedure / tariff code(s)	Anaesthetist	Expected stay (days)

Admission type: ☐ Elective ☐ Urgent ☐ Day case ☐ ICU / High care post-op

2. PATIENT DETAILS

Title	Surname	First name(s)

SA ID / Passport number	Date of birth	Age	Nationality

Sex: ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Home language	Occupation	Employer

Residential address	Postal code

Cell phone	Alternative phone	Email address

Preferred contact: ☐ Phone call ☐ SMS / WhatsApp ☐ Email

3. NEXT OF KIN / EMERGENCY CONTACT

Full name	Relationship to patient	Cell phone

Address (if different from patient)	Alternative phone

4. ACCOUNT & FUNDING DETAILS

Funding: ☐ Medical aid ☐ Private / self-pay ☐ COID / WCA (injury on duty) ☐ Other: _____

Medical aid scheme	Plan / option	Membership number

Dependant code	Main member full name	Main member ID number

Main member employer	Hospital authorisation number	Gap cover provider

COID: employer name & claim number (if injury on duty)	Date of injury	Referring doctor

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5. MEDICAL HISTORY

Please indicate whether you have, or have ever had, any of the following:

High blood pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Heart disease / angina	☐ Yes	☐ No
Heart attack / stent / bypass	☐ Yes	☐ No	Irregular heartbeat	☐ Yes	☐ No	Stroke / TIA	☐ Yes	☐ No
Epilepsy / seizures	☐ Yes	☐ No	Asthma / COPD	☐ Yes	☐ No	Sleep apnoea	☐ Yes	☐ No
Kidney disease	☐ Yes	☐ No	Liver disease / hepatitis	☐ Yes	☐ No	Thyroid disease	☐ Yes	☐ No
Bleeding / clotting disorder	☐ Yes	☐ No	DVT / pulmonary embolism	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Tuberculosis (TB)	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Anaemia	☐ Yes	☐ No

Other conditions / details of any 'Yes' above

Previous operations (procedure and year)

Anaesthetic problems (self)	☐ Yes	☐ No	Anaesthetic problems (family)	☐ Yes	☐ No	Previous blood transfusion	☐ Yes	☐ No

6. ALLERGIES

Known allergies: ☐ None known ☐ Medication ☐ Latex ☐ Iodine / contrast dye ☐ Plaster / dressings ☐ Food

Allergy details and reaction (e.g. rash, swelling, breathing difficulty)

7. CURRENT MEDICATION (INCLUDING SUPPLEMENTS AND OVER-THE-COUNTER)

Medication name	Dose	How often	Reason

Blood thinners (e.g. warfarin, aspirin, clopidogrel) ☐ Yes ☐ No

Name of blood thinner	Date of last dose	Stopped on doctor's instruction?

8. OTHER IMPORTANT INFORMATION

Pacemaker / defibrillator	☐ Yes	☐ No	Metal implants / clips / shunt	☐ Yes	☐ No	Previous spinal surgery	☐ Yes	☐ No
Pregnant (or possibly)	☐ Yes	☐ No	Breastfeeding	☐ Yes	☐ No	Smoker	☐ Yes	☐ No
Alcohol use	☐ Yes	☐ No	Dentures / loose teeth	☐ Yes	☐ No	Mobility aid / wheelchair	☐ Yes	☐ No

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Height (cm)	Weight (kg)	Smoking: amount per day	Alcohol: units per week

Implant / hardware details (type, site, year)

Special needs (interpreter, dietary, religious, disability)

9. PLEASE BRING ON THE DAY OF ADMISSION

- Your ID document or passport, and medical aid card
- Hospital authorisation number (if on medical aid) / COID claim documents (if injury on duty)
- All recent scans, X-rays and reports (CT, MRI, angiography) and any blood results
- All your current medication in its original packaging
- Comfortable clothing and toiletries; leave jewellery and valuables at home

Follow the fasting and medication instructions given to you by the practice, hospital or anaesthetist. If you develop a fever, infection or any new symptoms before your admission, please contact the rooms.

10. DECLARATION, CONSENT & FINANCIAL RESPONSIBILITY

☐ I confirm that the information I have provided on this form is true and complete to the best of my knowledge.

☐ I consent to Dr Hina Neurosurgery Inc collecting, processing and sharing my personal and health information with the admitting hospital, anaesthetist, assisting clinicians, my medical aid / funder and, where applicable, the Compensation Fund, for the purposes of my treatment, authorisation and billing, in accordance with the Protection of Personal Information Act (POPIA), 2013.

☐ I understand that I (or the main member / guarantor) remain responsible for any amount not covered by my medical aid or funder, including co-payments and shortfalls.

☐ I understand that a separate procedure-specific informed consent will be discussed with me and signed before surgery.

Patient full name	Signature	Date

Parent / guardian / main member (if applicable)	Signature	Relationship

Witness name	Witness signature	Date

FOR OFFICE USE ONLY

Received by	Date received	Authorisation confirmed	Quote issued

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