

APPLICATION FOR FUNDING OF CAESAREAN SECTION DELIVERY

PATIENT CONSENT

I, Membership No understand that all personal clinical information will be required to determine the indication for caesarian section. I give consent for my information to be shared with POLMED.

Member signature

Date

PATIENT INFORMATION

Please complete the following

Name and surname		Current gestational age (weeks)	
Membership number		Due date (mm/dd/yy)	
Place of delivery		Gravity	
Delivery admission date (mm/dd/yy)		Parity	

ELECTIVE (PLANNED) CAESAREAN SECTION

Please indicate the primary medical indication for a CS which applies to this application:

Medical Indication	Yes?	If YES, please provide the following information:	
Has the patient had any of the following previously • Caesarean section or • Uterine surgery (e.g. Myomectomy)?		Date of surgery:	
		Type of surgery:	
Do any of the following apply • Multiple pregnancy • Intrauterine growth retardation (IUGR) • Macrosomia • Polyhydramnios • Foetal malpresentation (e.g. breech, transverse lie, oblique lie) and gestational age > 36 weeks • Abnormal placentation (e.g. placenta previa vasa previa, placenta accrete/percreta) • Maternal pelvic deformity or disproportion		Which condition is applicable:	
		Please provide supporting Documentation (e.g. ultrasound report or other)	
Does the patient have HIV ?		Viral load count (copies/ml):	
		Is the patient on ARV's?	
Does the patient have medical conditions (e.g. cardiomyopathy, clotting/bleeding disorder), where labour would be dangerous?		Type of condition:	
		Current medication:	
Does the patient have pre-eclampsia ?		BP reading:	
		Medication:	

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ELECTIVE (PLANNED) CAESAREAN SECTION *(continued)*

Please indicate the primary medical indication for a CS which applies to this application

Medical Indication	Yes?	If YES, please provide the following information:	
Does the patient have any infection with significant risk of perinatal transmission during vaginal birth e.g. herpes simplex virus .		Type of condition:	
		Submit pathology/other result if available	
Other:			

EMERGENCY CAESAREAN SECTION

Please indicate the primary medical indication for a CS which applies to this application

Medical Indication	Yes?	If YES, please provide the following information:
Failure to progress during labour		Copy of Partogram
Foetal distress		Copy of cardiotocography (CTG)
Uterine rupture		
Abruptio placenta		
Cord presentation/Prolapse		
Chorioamnionitis (amniotic infection syndrome)		
HELLP syndrome		
Other:		

Date	
Treating doctor name	
Treating doctor practice number	

Signature of treating doctor

Please return form and any relevant documents to: Email: **Polmedauths@medscheme.co.za**

Privacy of information caution

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