UMVUZO HEALTH

Maternity Care Plan Form

GL NUMBER _____

rx health
an UMVUZO HEALTH Partner

MEMBER NUMBER _____

TO BE COMPLETED BY THE EXPECTANT MOTHER

DETAILS OF PRINCIPAL MEMBER

Membership number			
Surname			
Title		Initials	
Email address			

DETAILS OF EXPECTANT MOTHER

Surname					
First name				Title	
Address					
Email address					
Telephone number	(H)		(W)		
	(CELL)				

Preferred time of contact	Day	Monday		Tuesday		Wednesday		Thursday		Friday			
	Time	9:00		10:00		11:00		12:00		13:00		14:00		15:00		16:00	

I authorise my medical practitioner to furnish and/or disclose to Rx Health any information relating to this application, as well as any additional information that may be required from time to time.

Expectant mother's signature _____ Date D D M M Y Y Y Y

DETAILS OF DOCTOR

Surname		Initials	
Practice number		Telephone	

DETAILS OF GYNAECOLOGIST

Name	
Practice number	
Speciality	

MEDICAL INFORMATION

Are you currently being treated for any medical conditions, e.g. ASTHMA, DIABETES, HIV/AIDS, TUBERCULOSIS OR DEPRESSION? Y N

if yes, please list the condition(s):

_____

_____

_____

Weight		KG	Height		CM		
Smoking	Y N		Less than 12 months ago		More than 12 months ago		Stopped	
Alcohol	Y N	If yes, how often:	Daily		Occasionally		Weekly	
Exercise	Never		Less than 1 hour/week		More than 3 hours/week		1-3 hours/week	
Allergies	Aspirin		Penicillin		Sulphonamides			
Other								

PLEASE PROVIDE INFORMATION ON YOUR CURRENT PREGNANCY (IF FIRST CHILD, ONLY COMPLETE THIS SECTION)

Expected delivery date D D M M Y Y Y Y First day of last menstrual period D D M M Y Y Y Y

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PLEASE PROVIDE INFORMATION ON PREVIOUS PREGNANCIES

Number of Pregnancies		How many children do you have?	
Do you have Twins?	Y N	Triplets?	Y N

Have you previously experienced a MISCARRIAGE/ STILLBIRTH/ AN ECTOPIC PREGNANCY? Y N

If yes, please provide the details:

Were any of your babies born with health problems, e.g. PREMATURE, SPINAL CORD DEFECTS, CONGENITAL DEFECTS OR LATE STILLBIRTH? Y N

If yes, please provide the details (especially if the baby underwent surgery):

Have you previously had AMNIOCENTESIS tests carried out? Y N

If yes, please specify reason/s:

Were any of your babies born prematurely?	Y N	Did you carry 2 weeks over term?	Y N
How were your children delivered?	Caesarean birth		Vaginal birth
Did you experience any of the following during a vaginal birth?	Complications		Forceps-assisted birth (Delivery of baby with forceps)
	Induced labour		Vaccum extraction (Delivery of baby with suction device)

Provide the reasons for the caesarean birth (if applicable):

Elective (by choice)	
Other (please specify)	

Did you experience any of the following during pregnancy:

High blood pressure		Diabetes		Pre-eclampsia (High blood pressure with protein in the urine)	

If any other problems were experienced, please specify.

Indicate if any of the following complications were experienced after the birth of your child.

Breast problems		Placenta retention		Postnatal depression	
Severe bleeding		Wound infection			

Condition of baby(ies) after delivery:

Bleeding under scalp		Breathing problems		Neonatal jaundice (Yellowing of newborn's skin)	
Paralysis (Unable to move one or more limbs)				Other	

Did you breast feed your baby(ies)	Y N	If yes, for how long (weeks/months)?	

I hereby acknowledge that the scheme has appointed Rx Health (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner.

I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.

Whilst Rx Health undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Rx Health liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

Please email the completed form to Maternity@rxhealth.co.za