Bankmed
Yours in good health

Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Bariatric surgery application form

Purpose of this 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

1. Please use one letter per block, complete with black ink and print clearly or complete the form digitally.
2. To avoid administration delays, please ensure this application is completed in full.
3. Send the completed and signed form with the required clinical information and patient consent to us by e-mail to **clinical@bankmed.co.za**.

1. Referring Healthcare Professional details (must be a surgeon, physician or endocrinologist)

Specialist name

Speciality

Specialist BHF number | Specialist HPCSA registration number

Telephone | Fax

E-mail address

Healthcare Professional's signature | Date Y Y Y Y M M D D

Name of the 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)

Surgeon name

Specialist BHF number | Specialist HPCSA registration number

Telephone | Fax

E-mail address

Healthcare Professional's Signature | Date Y Y Y Y M M D D

3. Principal member details

Membership number

ID or passport number

Name

Surname

4. Patient details (to be completed by the patient or the member)

Title | | | | | Initial(s) | | | | | |

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) Telephone (W)

Cellphone

E-mail

Relationship to Principal 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 <150 kg)

Comorbid 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 comorbidities

What is the proposed surgical procedure?

Type of bariatric surgery:	Roux-en-Y	☐
	Biliopancreatic 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. Dietician report
9. Supporting documentation from an anaesthetist verifying that the patient is medically fit to undergo an anaesthetic procedure

6. Consent for collection of data for outcomes measurement and registry requirements

I, ______________________ (patient's name in full), hereby give Bankmed consent for the collection of all medical/clinical information pertaining to my application for ______________________ (name of medication/procedure/test) for the treatment of ______________________ (name of condition) as requested either by myself or my consulting Healthcare Professional ______________________ (Healthcare Professional's name in full). In addition, I specifically consent to Bankmed having access to my clinical records at my Healthcare Professional'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 Bankmed to make informed funding decisions. The confidential nature of the information Bankmed receives will be respected at all times. I understand that approval for funding for this treatment is confidencial upon my cooperation with all aspects of this pre-assessment.

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

Benefit only available for members over 18 years of age

*Up to date forms are always available on **www.bankmed.co.za**