Dear Sir / Madam

Thank you for contacting us with regards to the services we offer. We care for patients diagnosed with serious and often life limiting diseases, who require help and support in their time of need. See our Information Leaflet and Website: www.beaconofcare.co.za for more detailed explanation of the services we offer.

The following documentation is also required to enable us to expedite your new patient registration application:

- **Medical referral from the doctor who treated/or is treating you.**
- **Medical aid consent form (if applicable).**
- **The latest prescription(s).**

PATIENT INFORMATION

Surname:	**Full names:**	**Cell:**	
Marital status: single/mar/div/sep/wid	**ID no:**	**D.O.B.**	**Age:**
Language:	**Gender:** male / female / other	**Race:** A / B / C / W	
Physical address:			
Postal address:			
		Postal code:	
Details of contact person: (to make appointments etc.)	**Name:**	**Cell:**	
	Email address:	**Work no:**	
DIAGNOSIS: **ICD 10 Code (if known):** **Date of Initial Diagnosis:**			
Medical Aid: Yes / No	**Name:**	**Nr:**	

Medical professionals involved in current treatment

General Practitioner:	**Name:**	**Tel:**
	Email address:	**Area:**
Specialist / other Health care providers	**Name:**	**Tel:**
	Email address	**Hospital:**

Surgical history

Previous surgical interventions: **Attending Surgeon:**	

Source of referral (please circle or highlight one)

Self / family / friend / state Dr / GP / private specialist / social worker / Medical scheme / Other:

Contact details of next of kin

Name and Surname	Relationship to patient	Date of birth	Contact number

Medicine (if known)

Name of medication	Amount or milligram	How many times a day do you take it?	How long have you been taken this?

ENGAGEMENT LETTER

Patient:

I …….. ID ……..

of address……

hereby give consent to be treated by Beacon of Care NPC.

OR

I …….. ID ……..

Of address ……

As **legal guardian or Medical Proxy** of

patient : …….. ID ……..

Of address ……

Hereby give consent to be treated by Beacon of Care NPC.

- ✓ I agree to have previous medical records made available to Beacon of Care.
- ✓ I agree to keep Beacon of Care informed of any changes in clinical condition or medication.
- ✓ I agree to keep to the advice given by the Beacon of Care team regarding amount of visits needed, type of care needed, medication to be taken or any other advice deemed necessary.
- ✓ I accept that if I do not keep to these instructions, that my health or wellbeing will suffer and that Beacon of Care cannot be held responsible for any illness or injury resulting in not heeding advice given by the Beacon of Care team.
- ✓ Our staff and volunteers have the right to a safe working environment and to be treated with respect. We have the right to discharge any patient violating this principle.

FINANCIAL POLICY:

No patient will be turned away due to financial constraints. Each situation will be individually assessed.

We will bill the patient directly according to treatment given (at the usual Medical Aid rates). If you or your family cannot contribute to our costs, your account will be paid out of our fundraising events and donations received and we will leave it up the family to consider a contribution to help us cover the cost of care to the patient.

You will receive a weekly or monthly report on the number of times our Professional Nurse, Doctors or Ancillary services (Physiotherapist, Social worker, Occupational Therapist etc) visited the patient.

OUR BANKING DETAILS:

For contributions towards care or Donations.

Beacon of Care NPC

FNB Cheque Account

Account number: 62798587790

Branch Code: 255 355

INDEMNITY FORM

Although Beacon of Care endeavors to provide care of the highest degree, it **requires indemnity from** the patient.

Therefore I, ……..

The said lawful patient/ guardian of

……

Hereby absolve the employees of Beacon of Care, its voluntary helpers, agents, advisors or representatives, whether medical, nursing or otherwise, from any claims:

a) Of whatever nature, and howsoever arising including any claims arising from negligence on the part of the employees and servants of Beacon of Care or its voluntary helpers, agents, advisors, or representatives, whether medical, nursing or otherwise:

b) Whether for injuries, damages, death, consequential loss, damage to property or personal possessions.

Where such claims, but for this indemnity, would be actionable by him/her, his/her estate or his/her dependents and which arose directly or indirectly out of the provision of such care.

I furthermore absolve the employees and servants of Beacon of Care, its voluntary helpers, advisors or representatives, whether medical, nursing, or otherwise, from any claims referred to above.

SIGNATURE ……..

DATED AT …….. THIS …….. DAY OF ……..2019

Please send this completed form, together with a Referral Letter from your GP or Specialist (if possible) to the email below and one of our Professional Nurses will contact you within 24 hours to arrange a home visit or consultations as needed:

Kind regards,
Beacon of Care NPO

Contact us at:

info@beaconofcare.co.za

or phone:

064 138 5352 (available 24hours) for medical queries and

065 135 5214 (available 8:00 till 17:00, Monday to Friday) for admin queries.