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 may 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.

We need this form filled in plus the following:

- **Medical referral from the doctor who treated or is treating you currently (ESSENTIAL)**
- **Medical aid consent form (if applicable)**
- **A copy of your latest prescription**
- **A copy of your scan and x-ray results and any blood tests you may have had**

PATIENT DETAILS:

Surname:	**First name:**	**Cell:**	
Marital status:	**ID no:**	**D.O.B.**	**Age:**
Country born in: **Nationality:**	**Gender:**	**Preferred language:**	
Physical address:			
Email:			
Occupation before retirement or current employer or unemployed:			
Religion and relevant denomination:			
Another CONTACT PERSON details:	**Name:**	**Cell:**	
	Email address:	**Relationship:**	
DIAGNOSIS: **ICD 10 Code (if available):** **Date of Initial Diagnosis:** **Current symptoms:** **Chronic conditions:**			

Medical Aid: Yes / No	**Name:**	**No:**

Medical professionals involved in current treatment

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

Surgical history

Surgeries in the last year: **Attending Surgeon and hospital:**	

Source of referral (please circle 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

Medicines

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.

SIGNATURE……

DATE ……DAY OF …….. (MONTH) 2020.

FINANCIAL POLICY:

If a patient belongs to a Medical Aid, Beacon of Care will bill the patient directly and they can then claim back from the Medical Aid. If a patient does not belong to a Medical Aid, 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. No patient will be turned away due to financial constraints. Each situation will be individually assessed.

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

- If I do not have a medical aid OR my medical aid does not pay Beacon of Care the full amount invoiced, I agree to pay the rest of the account myself or my family agrees to pay for this service on my behalf if I am able to do so OR I give consent to fundraise on my behalf to cover the cost of my care.

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 patient ……..

OR 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, or external consultants for wound care, Occupational Therapy or other services as needed 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 ……..

DATE ……..DAY OF ……..(MONTH)2020.

Please send this completed form, together with a Referral Letter from your GP OR Specialist OR Clinic to the email below or hand it in at Ballito Medical Centre at the Well, corner of Kirsty and Albertina way for Attention of Dr Nothnagel, and one of our Nurses or Doctors will contact you within 24 hours to arrange a home visit or consultation as needed:

Kind regards,
Beacon of Care team

Please send above form to:

admin@beaconofcare.co.za

Or phone or whatsapp:

Sharon on 065 135 5214 for admin queries during office hours Monday to Friday

To be filled in by first admitting medical professional:

After hours (emergencies only):

Nurse name and number:_____

Doctor name and number: _____

Nearest hospital: _____

Ambulance number: _____