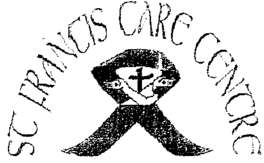

ST FRANCIS CARE CENTRE

30 Olivia Road
Eveleigh
BOKSBURG
St Francis Care Centre
PostNet Suite # 125
Private Bag X1
East Rand
1462

Tel: 011 894-4151, 4261, 4262
Fax: 011 894-5773

e-mail: tilly@stfranciscarecentre.co.za

REGISTRATION NO: 011-441 NPO

REQUIREMENTS FOR ADMISSION

- Results for Hiv status and CD 4 count
- Medical report to be completed by the Sister or Doctor who has seen the Patient.
- Has the Patient been investigated for TB?
- If yes results needed.
- Is the Patient on TB treatment?
- How long has the Patient been on treatment?
- If more than two weeks bring along the medication and green card.

MEDICAL REPORT TO ACCOMPANY APPLICATION FOR ADMISSION TO ST FRANCIS CARE CENTRE

Full Name of Patient:..

Diagnosis:...
....
....
....

Associated conditions:..
....
....
....

Relevant past medical history:...
....
....
....

Relevant investigations and results:..
....
....
....

Management:...
....
....
....

Present Treatment:...
....
....
....
....

Completed by: Name:..

Signature:...

Date:..

PATIENT APPLICATION FOR ADMISSION

Surname: First Names:

ID no.______________________ Date of Birth: __________________ Marital status: S / M - Civil / W / D / C / R

Home Address: ____

Place of birth :______________________________ Smoker : Yes / No Alcohol : Yes / No Social / problematic ?

Occupation : **Standard of Education :**

Religion : **Baptised : Yes / No**

Dependant children: Names & Ages ______________________________________

Left in whose care ? Other Dependants ?

Next of Kin: Name Relationship:

Address : ____

Tel. no : ______________________________ Cell no :

Who will be responsible for payment whilst at the Centre : ______________________

Basic Fees : Medical Aid Member: R250 per day Non-member : Admission Fee R100. Thereafter R100 per week.

If unable to afford these rates state how much you can afford ? ______________________

Do you receive a disability grant ? Yes / No If 'no' have you applied ? Yes / No

If patient is discharged who will collect patient ? ______________________________

In the event of death contact ? ______________________________ Cremation / Burial ?

Person responsible for funeral arrangements ______________________________

Patient referred by : ______________________________ Tel no______________

Signature of patient or responsible person ______________________________

Signature of admitting officer ______________________ Date ______________

Please note that this completed form must be returned together with the attached medical report and an acceptance obtained before patient arrival