MEDICAL PROTOCOL

Please note the following with regards to medical protocol at Healing Wings South Africa:

- A thorough medical assessment is carried out by our registered professional nurse, within 24 hours of arrival. Healing Wings utilizes the services of a consultant medical doctor practising in Nelspruit who is on call on a 24-hour basis. Our referring psychiatrist, based in Nelspruit, assesses and treats all residents in need of psychiatric care. ***We require that all medical and dental needs are attended to prior to admission to Healing Wings, in order to limit unnecessary trips into town early in recovery. Please ensure that you bring <u>at least</u> 2 weeks supply of your prescribed medication.***

- Please note that all residents on prescription medication need to supply Healing Wings with an original copy of their prescription for a repeat period of 6 months, prior to arrival. This prescription is to be accompanied by a medical report/letter from the residents prescribing doctor. Healing Wings South Africa cannot issue medication without an original script.

- PLEASE NOTE THAT A COPY OF THE APPLICANT'S ID AND MEDICAL AID CARD IS REQUIRED ON APPLICATION. SHOULD AN EMERGENCY ARISE AND NO ID OR MEDICAL AID CARD IS PRESENT, THE SPONSOR WILL BE LIABLE TO PAY PRIVATE MEDICAL RATES. FOREIGNERS ARE REQUIRED TO BRING VALID PASSPORTS.

- HEALING WINGS SOUTH AFRICA WILL NOT BE HELD LIABLE FOR ADDITIONAL COSTS INCURRED FOR FOREIGN RESIDENTS SHOULD THEIR VISAS EXPIRE.

- ***Medical Aid - Please note that Healing Wings South Africa does not claim directly from any medical aid scheme. Residents are required to pay Healing Wings South Africa and to then claim back from their medical aid on receipt of an official Healing Wings invoice. It is advisable to contact your medical aid and obtain pre-authorisation before admission to Healing Wings as this will ensure smooth processing of your claim and reimbursement. Please quote the Healing Wings practice number*** 0380091 when obtaining pre-authorisation. Please note that Healing Wings charges a R500.00 fee for the cost of administering accounts for reimbursement. This includes the cost of a medical professional completing a DSM-IV form regarding the admission to Healing Wings, which is required by all Medical Aid schemes, should this not have been done prior to arrival.

I understand and accept the terms and conditions with regards to Healing Wings South Africa medical centre protocol.

Sign (applicant): _____ ***Sign (sponsor):*** _____

Disclaimer:
By signing this document, I hereby confirm that all information disclosed and signed for on this document is (to my knowledge) 100% correct and accurate and that I have not failed to disclose or include any information which may prove vital.

Applicant Name: _____

Medical Confidentiality

Criteria to release Private and Confidential matters related to the Medical Fraternity

Healing Wings South Africa, and all its members, consider every residents' medical and healthcare information as highly confidential. All proceedings which take place in the Healing Wings medical room will be regarded as such.

Releasing of any medical and healthcare information will be done only with written consent of the Healing Wings resident – this applies to the duration of the residents in-patient stay at Healing Wings, as well as once the resident has the completed treatment (for any reason whatsoever).

This serves to confirm that I, _____ ID number: _____

I do give my consent for the release of my personal medical information on written request to:

1) My parents/guardian
2) Members of the Healing Wings South Africa Multi Professional Team
3) Another member of the medical fraternity to assist in providing me with the best healthcare possible

Sign: _____ Date: _____

Witness: Name: _____ Sign: _____

OR

This serves to confirm that I, _____ ID number: _____

Do not give my written consent to release any of my personal medical information to anybody on request.

Sign: _____ Date: _____

Witness: Name: _____ Sign: _____

Disclaimer:
By signing this document, I hereby confirm that all information disclosed and signed for on this document is (to my knowledge) 100% correct and accurate and that I have not failed to disclose or include any information which may prove vital.

Applicant Name: _____

PERSONAL MEDICAL INFORMATION

Please complete all the information needed on this form, to be used in the event of routine and medical emergency. Should the resident be on medical aid, please kindly supply a copy of both sides of their medical aid card. Please email current medical prescription for ALL scheduled medications prior to arrival, and bring the original script on admission. Prescription MUST state ***repeat*** for at least 3 – 6 months, still to be filled. Please ensure that you arrive with at least 2 weeks supply of your prescribed medication.

FULL NAMES OF RESIDENT
Identity Number
Current Medication
Medical Conditions/Allergies, E.g. Diabetes, Bi-Polar.
Family doctor, name and Tel number
Psychiatrist, Tel number
Medical Aid name & plan
Medical Aid number
Members Names **Dependant Number**
Medical Aid Plan: Comprehensive Plan, Hospital plan, other.
FULL NAMES OF RESPONSIBLE PERSON
Identity Number
Physical address
Postal Address
Telephone numbers **Work** **Cell** **Home**
NAME OF NEXT OF KIN of resident
Name
Contact numbers
E-mail address:

Disclaimer:
By signing this document, I hereby confirm that all information disclosed and signed for on this document is (to my knowledge) 100% correct and accurate and that I have not failed to disclose or include any information which may prove vital.

Applicant Name: _____

MEDICAL REPORT: *report on applicant's physical health (to be completed by a medical professional)*

PATIENT NAME:	
ID NUMBER:	
DATE OF SERVICE:	
D.O.B.:	
ALLERGIES:	
PAST MEDICAL HISTORY:	
PAST SURGICAL HISTORY:	
PSYCHIATRIC HISTORY:	
SOCIAL HISTORY:	
PHYSICAL EXAM:	
CURRENT MEDICATIONS: *(please provide an original repeat prescription for a minimum period of 6 months)*	
OBSERVATIONS:	
FIT FOR REHAB:	Is the patient fit for rehabilitation? YES / NO
DETOX:	Does the patient require detox? YES / NO Has the patient been detoxed already? Results of multi-drug urine test:
DOCTOR'S SIGNATURE & PRACTICE STAMP:	

Disclaimer:
By signing this document, I hereby confirm that all information disclosed and signed for on this document is (to my knowledge) 100% correct and accurate and that I have not failed to disclose or include any information which may prove vital.

Applicant Name: _____