



MATERNITY PROGRAMME APPLICATION

SECTION A: IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for enrolment per pregnancy.
2. Allow 5 working days for the processing of your application.
3. Please submit completed forms as incomplete information may delay registration.
4. Approval of enrolment is subject to the rules of the Scheme and its Administrators' Clinical Protocols.
5. Please send completed forms to wellbeing@bpmas.co.za or contact the Disease Risk Management team on 0800 001 607 with any queries.

SECTION B: BENEFICIARY DETAILS

Scheme:	Option:
Full Name:	Medical Aid Number:
ID/passport Number:	Date of Birth:
Tel Number:	Cell Number:
Email Address:	
Residential Address:	

Preferred form of communication (please tick one option): Tel Cell Email

SECTION C: HISTORY

Current weight:	kg	Height:	m	
Hip/Waist ratio:		Smoker? Y	N	Avg per day:
Alcohol:	Units/week	Allergies: Y	N	Specify:
Current blood pressure:	mmHg	Pulse:	/m	
Blood Glucose (HGT):	mmol/L			
Exercise: Frequency:	times a week	Type:		
Intensity (Tick):	Low	Medium	High	

Chronic Conditions:

Cardiovascular	Endocrine	Respiratory	Psychiatric	HIV
Other	Please specify:			

Chronic Authorisation: IHC



Medical Aid Number:

SECTION D: CURRENT PREGNANCY

Last Menstrual Period: _____ Expected Date of Delivery: _____
 Weeks Pregnant: _____ weeks Previous Pregnancies (including current pregnancy): _____
 Number of live births: _____
 Is this a multiple pregnancy? Y N If yes, Twins _____ Triplets _____
 Fertility Treatments? Y N
 Have you had any antenatal scans? Y N If yes, were any problems detected? _____

Are you currently suffering from any of the following pregnancy induced conditions?

Gestational Hypertension Pre-Eclampsia Gestational Diabetes Placenta Previa

Mode of delivery (planned):

Normal Vaginal Birth Caesarian Section *If yes, please select indication*
Elective Caesarian Previous Caesarian Multiple Births High Risk Pregnancy

SECTION E: PREVIOUS PREGNANCY

Have you ever had a multiple pregnancy? Y N If yes, Twins _____ Triplets _____
 Fertility Treatments? Y N

Have you previously had a miscarriage, stillbirth, ectopic pregnancy? Y N

If yes, please provide details:

Have you previously had amniocentesis tests carried out? Y N

If yes, please provide details:

Did you experience any of the following during previous pregnancies?

Small for gestational age Preterm labour Gestational Hypertension
 Pre-Eclampsia Gestational Diabetes Placenta Previa

SECTION F: PREVIOUS DELIVERIES

Previous deliveries?

Vaginal birth: Y N Number: _____ Caesarian: Y N Number: _____

Did you experience any of the following during a vaginal birth?

Induced labour Vacuum extraction Forceps
 Complications *Please specify:*

Please provide reasons for the caesarian delivery:

Elective caesarian Emergency caesarian Previous Caesar
 High Risk Pregnancy Other *Please specify*

Did you experience any of the following complications after the birth of your children?

Placental retention Severe bleeding Post partum infection
 Breast feeding problems Post natal depression

