REGISTRATION FORM: MEDICAL SERVICES
STRICTLY CONFIDENTIAL

GUIDELINES TO THIS FORM:

This form is for completion by a student accessing medical services at the DSA Student Wellness Service and should be emailed to Lerushda.cheddie@uct.ac.za, , Siphe.dukwana@uct.ac.za , Aggie.morole@uct.ac.za

Patients consent to process personal information.

I hereby consent to the processing of my personal information contemplated in the Protection of Personal Information Act No 4 of 2013, by Student Wellness Service Multidisciplinary Team, the practice staff and third parties with whom the Student Wellness Service has a contractual relationship for the following purposes:

1. Treating and managing me in terms of the doctor and patient relationship.
2. The administration of the contractual relationship between myself and Student Wellness Service.
3. I hereby consent to share my information with the Department of Health or any other authorized entity as required by law. This may include sharing information such as medical history, diagnoses, treatments, and additional information needed to ensure adequate healthcare provision.
4. Collecting of monies outstanding from me.
5. I understand that this information will be used solely to provide adequate healthcare services and that privacy will be protected under applicable laws and regulations.
6. I acknowledge that I have read and understood the above information and that I freely and voluntarily consent to share my medical information for the abovementioned purposes.

Name & Signature …… **Date**……..

SECTION A: STUDENT APPLICANT DETAILS **Note: to be completed by the student**						
Student Name & Surname						
Student Number		**Age**		**Date of birth**		
Faculty		**Course of study**				
Gender	**Male**			**Female**		
Year of study		**First year of registration**				
Telephone No.	**Term:**		**Cell:**			
UCT Email address						
University term/ Physical address (in Cape Town)						
Next of kin/ person to be contacted in an emergency						
Next of kin: contact no.		**Next of Kin: Relationship**				
Do you receive financial aid from NSFAS? ***(Bursaries & scholarships not included)***	**Yes**		**No**			
	If yes, please send a copy of the letter to sws@uct.ac.za so that consultation fees can be waivered					
Are you on Medical Aid?	**Yes**		**No**		**Name of Medical Aid**	
Membership No.						
Main member	**Name & Surname**		**Contact No.**			
List any serious medical/ psychological conditions/ disabilities that you suffered previously or currently						

List any surgery/ operations				
List any medication you are taking presently				
List any medication that you are allergic to				
I understand the following: • **There are certain charges for consultations, procedures, materials and tests** • **There are also charges for any referrals outside of student health.** • **I'm personally responsible for enquiring about any charges** • **I undertake to settle my accounts within 30 days of my date of consultation.** • **Clinical health professionals share medical records for the purpose of providing holistic health care**				
Student signature		**Date:**		
FOR OFFICE USE ONLY	**Capture Date**		**Admin Signature**	