

Date:

INFORMATION FOR REGISTRATION ON MATERNITY PROGRAMME:

I hereby wish to inform you that I have performed a pregnancy test/examination on:

Membership No	
Option	
Member Name	
Patient Name	

Contact Telephone Numbers (member):

Home	
Work	
Cell No.	
Email address	

MUST BE COMPLETED BY AN OBSTRETIICIAN/GYNACOLOGIST:

Patient's Details

Expected date of Delivery is:

Gravida: _____ . Para: _____ .

Risk factors: _____ .

The above member has been tested for HIV? Yes No

Doctor's Details

Name	Practice number	Tel No.	Email address

Thank you for your co-operation

.....
Doctor signature

.....
Date