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 OBSTRETICIAN/GYNACOLOGIST:

Name of Provider	

Patients' 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**

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