Bariatric surgery application form 2025

LA Health
Powered by Discovery

Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for LA Health Medical Scheme and takes care of the administration of your membership.

Contact us
Tel (members): **0860 103 933**, Tel (health partners): **0860 44 55 66**, **www.lahealth.co.za**, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form
This application form is to apply for funding for bariatric surgery. It must be completed by an accredited surgeon from an accredited centre of excellence who will be performing the surgery. The member must complete sections 3, 4 and 6 of this form. The turnaround time on receipt of a completed form is seven working days. We may need an additional three days if we need to send the request to an external advisory panel before we reach a funding decision.

How to complete this form

- Fill in the form in black ink and print clearly, or complete the form digitally by using Adobe Acrobat Reader.
- To avoid administration delays, please ensure this application is completed in full.
- Send the completed and signed form with the required clinical information and patient consent to us by email at **motivations@discovery.co.za**.

1. Referring healthcare professional details (must be a surgeon, physician or endocrinologist)

Title | Initials

Surname

First name(s) (as per identity document)

Speciality

Specialist BHF number | Specialist HPCSA registration number

Telephone (H) | Telephone (W)

Cellphone

Email

Doctor's signature | Date D D M M Y Y Y Y

Name of facility where the procedure will be done

BHF number of the facility where the procedure will be done

2. Details of the surgeon performing the procedure (if it differs from section 1)

Title | Initials

Surname

First name(s) (as per identity document)

Speciality

Specialist BHF number | Specialist HPCSA registration number

Telephone (H) | Telephone (W)

Cellphone

LAHBSA001

Email

Doctor's signature

Date D D M M Y Y Y Y

3. Main member details

Membership number

ID or passport number

Member's surname

Member's name

4. Patient's details

Title

Initials

Surname

First name(s) (as per identity document)

ID or passport number

Membership number

Telephone (H)

Telephone (W)

Cellphone

Email

Relationship to main member

5. Clinical history

1.Current weight in kilograms (kg)

2. Height in centimetres (cm)

3. Waist circumference in centimetres (cm)

4. Body Mass Index (BMI)

5. Blood pressure systolic/diastolic

6. Body fat % (only for patients <150kg)

Co-morbid illnesses

1. Diabetes mellitus
2. Hypertension
3. Dyslipidaemia
4. Coronary artery disease
5. Other (specify)

Please note: Attach script for the treatment of the above co-morbidities.

What is the proposed surgical procedure?

Type of bariatric surgery: Roux-en-Y / Bilopancreatic diversion (BPD) / Gastric sleeve / Gastric band

Please attach the following to this application form

1. Report from endocrinologist/physician
2. Report from bariatric surgeon
3. Report from clinical psychologist/psychiatrist
4. Copy of blood results (e.g. fasting glucose, lipogram, TSH, ALT/GGT, CRP etc.)
5. Copy of gastroscopy report
6. Report from biokineticist/physiotherapist (where applicable)
7. Sleep apnoea studies (where applicable)
8. Dietitian report
9. Supporting documentation from an anaesthetist that the patient is medically fit to undergo an anaesthetic procedure

Please note that this form expires on 31/03/2026. Up to date forms are available on www.lahealth.co.za.

LA Health Medical Scheme, registration number 1145, is administered by Discovery Health (Pty) Ltd, registration number 1997/013480/07. Discovery Health (Pty) Ltd is an authorised financial services provider.

6. Consent to collection of data for outcomes measurement and registry requirements

I, ______________________ (patient's name in full),
hereby give LA Health Medical Scheme and Discovery Health (Pty) Ltd consent to the collection of all medical/clinical information pertaining to my application for ______________________ (name of condition)
as requested either from myself or my consulting doctor, ______________________ (doctor's name in full)

In addition I specifically consent to LA Health Medical Scheme and Discovery Health (Pty) Ltd having access to my clinical records at my doctor's rooms for the purposes of conducting clinical audits. The information will be used for the purposes of measuring clinical outcomes and developing a registry that will allow LA Health Medical Scheme to make informed funding decisions. The confidential nature of the information LA Health Medical Scheme and Discovery Health (Pty) Ltd receives will be respected at all times. I understand that approval for funding for this treatment is conditional upon me cooperating with all aspects of this pre-assessment.

Patient's signature ______________________

Date D D M M Y Y Y Y