

Hospital admission feedback form 2024



Contact us

Tel (members): 0860 99 88 77, Tel (health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, www.discovery.co.za, 1 Discovery Place, Sandton, 2196.

Ensuring you get the best hospital care possible

Discovery Health is committed to ensuring you receive safe, high-quality care if you are admitted to hospital. We try to work constructively with hospitals, doctors and other clinical staff to improve quality and safety and to address any concerns our members may have, as they arise.

Usually it is best to take your concerns directly to your doctor or hospital, but sometimes that is ineffective. In such circumstances, we are happy to relay your concerns or complaints (or compliments) to the relevant hospital managers, and to work with you to have them effectively addressed.

The 'Hospital admission feedback process' only **applies** to comments about an admission to **hospital**. Discovery Health cannot act on complaints against other types of healthcare providers. These kinds of complaints can be sent to the Health Professionals Council of South Africa on info@hpcs.co.za

Your feedback is important for resolving your current issues, also for preventing further harm, discomfort and dissatisfaction in the future.

Tell us about your hospital stay

The purpose of this form is to make it possible for us to give the hospital feedback. We want to assist you to create awareness to allow the hospital to understand what has happened, particularly when a hospital admission has resulted in harm to you or a family member that could have been prevented. Please use the form to collect information that can identify when and where your care took place, who was involved, and what happened to you or your family member.

What we will do with this form

- We will review the information you provide. Usually, we send this to the hospital concerned. Sometimes it may be sent to the head office of the hospital group.
- We will not share any personal identifiable information with external individuals or parties without your permission.
- We may contact you to get further information

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be signed by the main applicant. The main applicant must sign and date any changes.
- Submit your documents by using the Get Help tool on www.discovery.co.za Under Medical Aid, select Get Help, click on 'send us a query' and follow the prompts
- This form is also available on the Discovery website: www.discovery.co.za

1. Member information

Name of patient involved	<input type="text"/>													
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Telephone (W)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>							
Email	<input type="text"/>													
Medical Scheme membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Medical Scheme name	<input type="text"/>													
Hospital name	<input type="text"/>													
Date of admission/incident	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

