

LIZANÉ VAN GRAAN

CLINICAL PSYCHOLOGIST

064 285 8179

lvclinicalpsych@gmail.com

REFERRING PRACTITIONER (if applicable)			
REFERRING PRACTITIONER:	SCOPE OF PRACTICE: (e.g. Psychology; OT)	PRACTICE NUMBER:	
1. MINOR PATIENT INFORMATION (PATIENT UNDER 18 YEARS)			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
HOME LANGUAGE:	RESIDENTIAL ADDRESS:		
WITH WHOM DOES THE MINOR RESIDE:			
PAYMENT METHOD: (for accurate record-keeping)		IF CLAIM IS TO BE SENT TO THE MEDICAL AID:	
CASH: <input type="checkbox"/>	LAST 4 DIGITS OF CARD: _____	MEDICAL AID DEPENDENT CODE: _____	
CARD: <input type="checkbox"/>			
CURRENT SCHOOL GRADE:	SCHOOL NAME:		
SCHOOL CONTACT DETAILS: <i>(We will only contact your child's school/teacher for therapeutic purposes. Information will only be provided to a specific person nominated by you at the school, with your written consent.)</i>		<input type="checkbox"/>	
2. MOTHER / GUARDIAN / CAREGIVER			
(please note that as we are unable to verify agreements between parents / caregivers, the adult who brought the child for healthcare will be liable for the account if the medical scheme does not pay, or does not pay for the care in full)			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
HOME LANGUAGE:	E-MAIL ADDRESS:	2 ND E-MAIL ADDRESS: (if applicable)	
POSTAL ADDRESS:		RESIDENTIAL ADDRESS: (if different from Postal Address)	
HOME 	WORK 	MOBILE 	
MEDICAL AID & PLAN:	MEDICAL AID #:	DEPENDENT CODE:	

ARMANSIS MEDICAL CENTRE
12 LUDORF STREET
BRITS, 0250

B.A. HONS (PSYCH)(NWU) / B.A. HONS – PRACTICAL PSYCHOMETRY
M.A. CLINICAL PSYCHOLOGY (UL)
CLINICAL PSYCHOLOGIST &
INDEPENDENT PSYCHOMETRIST

PS0133892 PR0724394 PMT0081876 PR0636282

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	MAIN MEMBER? YES <input type="checkbox"/> NO <input type="checkbox"/>		_____
OCCUPATION:	EMPLOYER NAME:		
EMPLOYER CONTACT DETAILS: <i>(We will only contact your employer if we are unable to reach you for account purposes. Healthcare information will only be provided to a specific person nominated by you at your employer, with your written consent.)</i>	_____	_____	
FAMILY / FRIEND CONTACT DETAILS: <i>(for account purposes should we be unable to contact you)</i>	_____	_____	
NAME: _____			
I hereby accept that –			
E-mail <input type="checkbox"/> YES <input type="checkbox"/> NO and/or SMS <input type="checkbox"/> YES <input type="checkbox"/> NO and/or Whatsapp <input type="checkbox"/> YES <input type="checkbox"/> NO			
messages may be sent to me in order to confirm appointment and convey general information of the practice and my child's healthcare, if child is younger than 12 years or older than and have agreed to me, the parent/caregiver/guardian receiving the information.			

2. FATHER / GUARDIAN / CAREGIVER			
(please note that as we are unable to verify agreements between parents / caregivers, the adult who brought the child for healthcare will be liable for the account if the medical scheme does not pay, or does not pay for the care in full)			
SURNAME:	FULL NAMES:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Prof. <input type="checkbox"/> Mx.
IDENTIFICATION NUMBER:	BIRTH DATE: / /	GENDER:	
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HOME :	WORK :	MOBILE :	
MEDICAL AID & PLAN:	MEDICAL AID #:	DEPENDENT CODE: _____	
	MAIN MEMBER? YES <input type="checkbox"/> NO <input type="checkbox"/>		
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