CONSENT FORM FOR ADMISSION AS AN IN-PATIENT

PATIENT'S DETAILS	
Surname:	Name:
Date of Birth:	UHID:
Date of Admission (if applicable):	IPID (if applicable):
Residential Address:	Gender:
Doctor:	Panel:
Phone number (mobile):	Phone number (Home/office):
Name of next of Kin:	Name of next of Kin:

CONTENTS OF CONSENT FORM

You (or the above-named patient in case a Representative is signing on your behalf1) are about to be admitted at .....(the "Hospital"), one of the institutions owned and operated by C-Care (Mauritius) Ltd ("C-Care").

In this context, it is mandatory that we obtain your consent – or, if you are unable to give personally your consent, that of your legally authorized representative (LAR)2 or next of kin (a "Representative"), before any medical care and/or treatment is conducted.

Before signing this consent form, you are invited to read carefully the below information and to ask any question you may have to your treating doctor or to any other healthcare professional of the Hospital.

You may also withdraw your consent at any point of time, including after having signed this form, provided that you inform your treating doctor and that you submit the withdrawal in writing.

TREATING DOCTOR

You may choose your treating doctor, depending on the latter's availability. In all other cases, and in particular in case of emergency, any other medical practitioner consulting at the Hospital with appropriate professional knowledge and skills will provide medical services to you.

In your interest, a second opinion or expert advice may be requested and/or you may be referred to a suitably qualified colleague of the treating doctor where necessary. In such a case, your treating doctor will provide all relevant information to the said colleague.

You are under the responsibility of your treating doctor, and we wish to highlight the fact that your treating doctor may not be employed by C-Care and therefore acts independently, in consequence of which C-Care/the Hospital would not be liable for any act or omission of the said treating doctor.

You must ensure that you are explained, in a language that you can understand, appropriate information regarding the proposed care plan or treatment plan or procedure(s), their expected duration and benefits, the potential risks related thereto and the ones of any other available treatment or procedure(s) (including no treatment or no procedure) and the associated costs, so that you may make a voluntary choice to accept or refuse a treatment and/or procedure.

Admission as inpatient adult patient

1. **"You"** shall be read and construed as if it was replaced by "Patient" whose details are given at the top of this document in case a Representative is signing on the Patient's behalf.
2. **Legally Authorised Representative** means an individual or judicial or other body authorised under applicable law to consent on behalf of the Patient .
3. **"Personal information"** means any information relating to you from which you can be identified. It does not include data where your identity has been removed (anonymous data).

ADMISSION AS INPATIENT ADULT PATIENT

If you need to undergo specific procedures such as anaesthesia, surgery, blood product transfusion, hazardous assessment, participation in research projects, photographic and audio-visual recording, unusual medications and routes of administration or any other investigations that involve significant risks or side effects, a specific consent form will be submitted to you - or your Representative as applicable. The additional consent form will be more detailed as regards to the specific procedure to be undergone by you and the same will be supplemental to this general consent form. For any laboratory test that is outsourced, C-Lab will act as facilitator and cannot be held liable for the results and turnaround times of the reports.

EMERGENCY PROCEDURE

Your treating doctor or any other medical practitioner at the Hospital will perform any emergency medical/surgical/ investigative procedure without obtaining your prior consent – or that of your Representative –in case the registered medical practitioner considers lifesaving treatment is required, your treating doctor or any other medical practitioner at the Hospital will perform any emergency medical/surgical/investigative procedure without obtaining your prior consent - or that of your Representative . If such a situation occurs, you will be treated according to the established emergency procedure at the Hospital.

POSSIBILITY OF TRANSFER

I have been informed that I or the patient may be transferred between C-Care entities during my treatment depending on the facilities availabilities and the medical practitioner's discretion.

RISKS

I have been informed that I or the patient may be transferred between C-Care entities during my treatment depending on the facilities availabilities and the medical practitioner's discretion.

PAYMENT OF FEES

There will be costs following your admission and stay at the Hospital (the "Costs") which will need to be settled upon presentation of the final bill.

I am willing to take a.....Room for which the Tariff is Rs.....per 24 hours .

ADDITIONAL ROOM RENT CALCULATIONS

ROOM OCCUPANCY (< 24 HRS) AT TIME OF DISCHARGE	TARIFF
As from 3hrs to 12 hrs	Half Room Rent
After 12 hrs	One Room Rent

We reserve the right to charge you a late discharge fee in the event there has been any delay in leaving the room .

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☐ I AM AN INSURANCE PATIENT

If you have a health insurance plan and we have an agreement with your insurance company, you will be requested to produce your insurance policy card at the time of admission. It is your responsibility to confirm with your insurance company the level of cover available to you. Any service rendered at the Hospital during your stay that is not totally covered by your insurance will be borne by you who will remain personally liable to pay any such amount. Such outstanding costs shall be immediately due and payable to the Hospital upon presentation of the relevant bill(s).

☐ I AM A CORPORATE REFERRED PATIENT

I will be personally liable to pay any excess amount in the event I am not fully covered by my company. I hereby unequivocally bind myself to pay the Hospital directly as and when the bills are presented to me for any service rendered during my stay at the Hospital which is not covered by my company.

☐ I AM A CASH-PAYING PATIENT

I hereby agree that my admission is subject to the payment of a deposit of an amount of Rs..... ; based on the nature of treatment and I have also been explained about the billing and discharge process. Please refer to the leaflets for more details.

I further understand that any excess amount of deposit shall be refunded to me/patient within a maximum time limit of 10 working days following discharge.

I acknowledge and agree that, in accordance with the provisions stated in The Financial Intelligence and Anti-Money Laundering Act (FIAMLA) 2002, it is prohibited to make any cash payment exceeding Rs 500,000, or its foreign currency equivalent, on my behalf during my current hospital admission.

We reserve the right to charge you interest in case of delay in payment and /or refer the matter to our attorney to recover any amount due, and in which case you shall be charged for all the cost incurred by the Hospital in pursuing collection including, but not limited to, attorney's fees, and other costs incurred by the Hospital as a result thereof.

PRIVACY STATEMENT

In the context of your admission at the Hospital, your personal information, including medical data, will be collected, both in paper and/or electronic form and/or processed by C-Care (including the Hospital's staff), your treating doctor and other health practitioners responsible, in particular for Your care, treatment, and health assessment. Same will be done in compliance with the Data Protection Act 2017 and/or, where applicable, the European General Data Protection Regulations ("GDPR").

This information will be collected for the purpose of providing comprehensive healthcare to you (including your health assessment, treatment and/or care, including tests and medical examinations). This information will be retained on Your record and will be shared with the medical team at the Hospital for purposes of administering and rendering medical care to You, but also for the billing, invoicing and settlement of your account with us and/or with Your insurance carriers for billing purposes. Your record may also be disclosed to a third party if necessary to protect Your vital interests, including to render emergency medical care or where required by law. Your record will otherwise be kept confidential.

For more detailed information about how your personal information will be processed and your various rights, please take the time to carefully read our Privacy Notice available in electronic form on https://c-care.com/mu/privacy-notice-patients/ or in paper form at the Hospital upon request. We remain available to answer any question you may have about its content.

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GENERAL INFORMATION

1. You are responsible for your personal belongings, money and valuables whilst admitted at the Hospital. C-Care will not be liable for any loss or damage to any of your personal belongings, money, and valuables.

2. I have been informed that due care would be taken by the hospital authorities to protect me during my stay as per the hospital's Policy.

3. Visiting Hours:
   i) C-Care Darné
   10:00 to 11:00hrs and 16:00 to 19:00hrs (Wards)
   10:00 to 11:00hrs and 19:00 to 20:00hrs (ICU)

   ii) C-Care Wellkin:
   13:00 to 14:00hrs, and 18:00 to 20:00hrs (Ward s)
   11:00 to 12:00hrs and 18:00 to 19:00hrs (ICU)
   13:00 to 14:00hrs, and 19:00 to 20:00hrs (Maternity Ward)

4. Visitors are not allowed to stay with the Patient during non-visiting hours, but one person may stay with the patient in case the patient is vulnerable.

5. In the event that the patient is above 75+, for his own security the patient shall be admitted in a single room and one person **COMPULSORILY** should stay with the patient.

6. Furthermore, following an assessment by the nursing team , any patient irrespective of age, may be requested to have a person to stay with him/her in a single room.

7. You may contact the Patient Support Officers if you have any complaints or grievances.

8. No flowers are allowed within our hospital premises.

9. Mobile phones are not allowed within the ICU and Covid ICU wards.

10. Food and beverage service is available on the ground floor at the cafeteria.

11. Room rates are subject to availability. Please refer to the attached excel sheet for our room rates per category.

I have been explained this consent form in a language which I fully understand.

Patient's:	Signature:	Date:
Witness:	Signature:	Date:
Name of Witness[1]: [1] A witness should sign this form if the patient, who is competent to sign, has indicated his or her consent but is physically unable to sign. Witness consents to the processing of his/her personal data in order to be compliant with the Data Protection laws applicable in Mauritius.		

If patient is unable to give consent:

Signature:	Date:
Name of Next of Kin / Parent / Guardian / Curator [2] (as applicable):	
National identity card number/ Passport number of Next of Kin / Parent / Guardian / Curator:	
Residential Address of Next of Kin:	
Contact details of Next of Kin:	
Capacity / Relationship with patient: [2]Next of Kin/Parent/Guardian/Curator consents to the processing of his/her personal data in order to be compliant with the Data Protection laws applicable in Mauritius.	

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