REGENERATIVE MEDICINE
NZ STEM CELL TREATMENT CENTRE

CANDIDATE APPLICATION FORM

Name: DOB: Age:

Address:

City: Postcode: Country:

Home phone: Country Code | Area Code | Number

Cell phone: Country Code | Area Code | Number

Email:

Usual GP:

My main problem is:

MEDICAL AND SOCIAL BACKGROUND

Are you? ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Occupation:

Currently Employed: ◯ Full Time ◯ Part Time ◯ Unemployed ◯ Retired

Do you currently smoke? ◯ Yes ◯ No If yes, how many cigarettes per day

Have you ever smoked? ◯ Yes ◯ No If yes, how many cigarettes per day for how many years

Do you drink alcohol? ◯ Yes ◯ No If yes, how many drinks per day?

Have you ever had a blood transfusion? ◯ Yes ◯ No

Do you have a communicable disease (e.g. HIV, AIDS, Hepatitis) ◯ Yes ◯ No

If yes, please specify

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Current weight (Kg):

Current height (cm):

◯ I walk 100% without assistance ◯ I currently use a walking stick or walker

◯ I currently use a wheelchair or motorised device ◯ Other

Please indicate if you have a history of any of the following:

◯ Heart Failure	◯ Heart Attack	◯ Stroke	◯ High Blood Pressure
◯ COPD/Emphysema	◯ Kidney Disease	◯ Ulcer Disease	◯ Hepatitis
◯ Diabetes	◯ Artificial Joints	◯ Kidney Stones	◯ High Cholesterol
◯ Artificial Heart Valves	◯ History of Cancer	◯ Active Cancer	◯ Active Infections (e.g. flu)

Other Medical problems

01.	**06.**
02.	**07.**
03.	**08.**
04.	**09.**
05.	**10.**

Previous Surgery	Dates
01.	
02.	
03.	
04.	
05.	
06.	
07.	

Were there any surgical complications?

Current medications:

Current over the counter medications:

Allergies

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HAVE YOU HAD ANY OF THE FOLLOWING? If YES, explain below.

Eyes
- ◯ Decreased Vision
- ◯ Blurred Vision
- ◯ Double Vision

Pulmonary (Lung)
- ◯ Shortness of breath
- ◯ Chronic Cough
- ◯ Coughing of blood
- ◯ Asthma
- ◯ Emphysema
- ◯ Tuberculosis

Gastrointestinal
- ◯ Weight Loss
- ◯ Decreased Appetite
- ◯ Change in Bowels
- ◯ Blood in Stool
- ◯ Gallbladder Disease
- ◯ Liver/Cirrhosis
- ◯ Hepatitis
- ◯ Ulcer

Endocrine
- ◯ Diabetes
- ◯ Goiter
- ◯ Thyroid

Ears, Nose, Mouth and Throat
- ◯ Decreased Hearing
- ◯ Ringing in Ears
- ◯ Mouth Pain or Swelling

Cardiac (Heart)
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ Chest Pain
- ◯ Heart Murmur
- ◯ Heart Palpitations

Muscular / Skeletal
- ◯ Back Pain
- ◯ Arthritis / Rheumatism
- ◯ Muscle Pain or Weakness
- ◯ Osteoporosis

Neurologic
- ◯ Headaches
- ◯ Dizzy / Faint Spells
- ◯ Nervous Disorders
- ◯ Epilepsy / Seizures
- ◯ Stroke

Allergies
- ◯ To Dust
- ◯ To Plants
- ◯ To Animals
- ◯ To Iodine
- ◯ To Plaster

Urinary Tract
- ◯ Kidney Trouble
- ◯ Kidney Stone
- ◯ Bloody Urine
- ◯ Frequent Urination
- ◯ Painful Urination
- ◯ Sugar/Albumin Urine
- ◯ Passing Urine/Night
- ◯ Slow Starting/Urine
- ◯ Weak Urine Stream
- ◯ Incontinence
- ◯ Prostate Disease
- ◯ Frequent Urine Infection

Psychiatric
- ◯ Mental Illness
- ◯ Depression
- ◯ Nervous Disorders

Reproductive System
- ◯ STD
- ◯ HIV Positive
- ◯ Breast Lumps
- ◯ Breast Pain
- ◯ Nipple Discharge
- ◯ Impotence

Explanation

FINANCIAL POLICY

The fee quoted to you includes administration, the doctor's time, nursing care, pre and post-operative clinic visits. All quotes are valid for 3 months.

To establish your health condition prior to deployment of SVF, you may be requested to have specific lab work, ECG, spirometry or radiology. This may be covered by private medical insurance.

When SVF is scheduled, a **non-refundable $1,000 deposit** is required to secure your theatre booking. The remaining balance of the fee is **due two weeks prior** to your deployment procedure.

In the event of cancellation of the procedure within seven days of the scheduled deployment date, 50% of the fees are non-refundable.

I understand the above financial policy.

Patient name :

Patient signature :

Date:

Doctors signature :
(to be signed at consultation if application approved)

Date:

FOR STAFF ONLY ◯ No active infections ◯ No active cancer ◯ Qualifies as a candidate