1153 Justice Mahomed Street, Brooklyn, Pretoria
Postnet Suite 308, Private Bag x 20009, Garsfontein

Tel: 012 346 3169 / 6786
Fax: 012 346 7798
E-mail: marloelana@slenderwonder.co.za
Website: www.slenderwonder.co.za

Slender Wonder Medical Weight Loss PTY (Ltd)
Reg no: 2007/032943/07 Vat no: 4600252680

PATIENT DETAILS

Surname: _____

Name: _____

Title: _____

Initials:_____

Birth date:_____

Age:_____

Physical Address:_____

_____Code:_____

Cell Nr:_____

Home Tel: _____

Work Tel: _____

Employer: _____

Marital Status: Single Married Divorced

Family Doctor: _____

Where did you find out about Slender Wonder? _____

_____

Date: _____ Signature:_____

Slender Wonder

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PATIENT MEDICAL HISTORY FORM

Dr Pieter Neethling
MB Ch B (2010)
Prac nr 0750735
MP 0727725

NEW NOW
AESTHETICS

Dr Gys Neethling
MB Ch B (2015)
Prac nr 0779199
MP 0820563

NAME: _____

MEDICAL

Previous illnesses and operations?

_____

_____

Present chronic ailments? (e.g. High blood pressure, diabetes)

_____

What medication are you using?

_____

Allergies to food and/or medication?

_____

HABITS

1) Do you smoke and how many? _____
2) Alcohol consumption?_____

Do you suffer from depression/stress/anxiety/emotional disorders?

_____

What appetite suppressants, if any, have you used?

_____

HAVE YOU EVER BEEN DIAGNOSED WITH

Bipolar mood disorder _____

MEN

Testicular Cancer: _____
Prostate Cancer: _____
Any other form of cancer: _____

WOMEN

When was your normal last period?_____
Are you pregnant? _____
Pregnancies: _____
Number of children: _____

Have you ever been diagnosed with any form of cancer?

_____

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PATIENT BACKGROUND, MEDICAL AND WEIGHT HISTORY FORM

PATIENTS' HISTORY

How long have you been overweight?

_____

What do you think is the main cause?

_____

What is your favourite food or drink or snack?

_____

What physical activities do you take part in?

_____

Have you had previous treatment for weight loss?
If so, where? _____

Which appetite suppressants, if any, have you used?

_____

Which other weight loss methods have you tried?

_____

Which worked the best?

_____

Does any of your family members have weight loss problems (mother/siblings)?

_____

Previous surgeries?

_____

Any chronic diseases?

_____

Do you have any allergies (food & medication)?

_____

Please list those allergies:

_____

Do you smoke? _____

For how long?_____How many per day? _____

Do you consume alcohol regularly?

_____

Do you suffer from: Stress / Anxiety / Depression / Emotional Disorder?

_____

WOMAN

Pregnancies: _____

Number of children? _____

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PATIENT ACKNOWLEDGEMENT OF DETAILS OF THE SLENDER WONDER PROGRAMME

Patient Name: _____
Do you require vegetarian products? _____
Slender Wonder First Month Pack includes the following:

Doctor's Consultation
Booster Injection (with HCG)
One month's injections (14 supplied at first visit; rest supplied at the two week follow-up) and/or Lipo Lite Drops
Protein Plus Shake (900g)
4 pack (Herba Boost, Magnetine, Pyruvite, Omega)
KL Cleanze
Wonder Cleanze
CLA
Diet Book
Anthropometrical Measurements: e.g. Medsci/Bodystat

Optional Products:

Aqua Cherry	Add to water to increase water intake and boosts metabolism
Garcinia Cambogia Plus	Natural Appetite Suppressant
Lipo Lite Drops	Curbs cravings and helps you to feel fuller for longer
3 in 1	A fibre-rich supplement to keep you fuller for longer and may assist in preventing/relieving constipation
CLA	Inhibits storing fat and aids the fat-burning mechanisms
Prime Lipoic Acid (PLA)	Anti-oxidant, assist in energy production, curbs sugar cravings and improve blood glucose stability

Protein Bars	Chocolate and Cookies & Cream
Protein Plus Shakes (450g) Two weeks	Mixed Berry, Fruits of the Forest, Tropical, Choc Mint, Banana & Toffee, Pinacolada, Chocolate, Cookies & Cream, Blueberry, Strawberry, Vanilla
Slender Wonder Shaker	
Recipe Books	Recipe Books I and II
Ready Made Meals (Fresh & Frozen)	Product and Price lists available from meals@slenderwonder.co.za
Sweetener	200g, 750g and 1g sachets (50)

All Slender Wonder Products are labelled as such, and are sold in sealed Slender Wonder containers.

Other products (Slender Wonder Products): _____

_____

Comments from Medical Practitioner:

_____

_____

Would you like to receive communication from Slender Wonder Brooklyn?

Yes / No

If yes, how?

SMS | EMAIL | TELEPHONE

Slender Wonder

I have been informed that this is a cash practice, and that most treatments will not be covered by medical aid. For treatments covered by medical aid, I will be responsible for settling the bill on the day of treatment and will then submit the account to my medical aid.
I agree to being help liable for the costs of any scheduled appointment in the event of failure to cancel the said appointment with less than 24-hours' notice.
Contra indications for hCG injections:
1. History of hormonal cancer (breast, endometrial, ovarian, prostate)
2. Uncontrolled or newly diagnosed blood clotting disorder.

Precautions for hCG injections:
1. History of gallstones
2. Bipolar disorder

Important: The hormone hCG injection is prescribed OFF LABEL for 6 weeks at a time, with a 2-6 weeks break in between cycles. If a patient does not lose a minimum of 4 kg the 1st month, an no medical reason can be found for this, the doctor can terminate the program (as it is not in the patient's best interest to continue with the program while cheating all the time, it promotes resistance to the hCG) As hCG is a prescribed medication, injections can't be purchased over the counter. I have read the above and agree with the terms and conditions. I do not have any medical conditions that have not been disclosed to the doctor.
You are required to return for a follow-up after two weeks. During this visit your progress is monitored and discussed with the Doctor. A booster injection and the rest of the daily injections are supplied. The Slender Wonder Programme can be done in three six-weekly cycles. In a six week cycle, up to 12kg can be lost if the programme is strictly adhered to. When three six-weekly cycles are completed and the goal weight was not yet reached, you have to discuss next steps with the Slender Wonder Doctor.

I have read the above and agree with the terms and conditions:

Patient: _____ Date: _____

Doctor: _____

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INDEMNITY: MEDICAL PRACTITIONER

AGREEMENT BETWEEN PATIENT AND MEDICAL PRACTITIONER

I, (full names & surname) _____
Membership No.: _____
Medical Scheme: _____
Tel: _____ Email:_____
the undersigned, hereby unconditionally accepts the treatment of Drs PS Neethling & GH Neethling of New Now Aesthetics for the Slender Wonder Weight Loss Programme ("SWWLP"),

1. confirm that:
1.1. I am fully aware of the practitioner's tariffs and accept them unconditionally.
1.2. The SWWLP may be repeated with my express written consent.
I am aware of the fact that my medical scheme does NOT pay for the SWWLP because they deem it to be cosmetic treatment, and I accept responsibility for payment of the amount due for professional services rendered and medicine dispensed and supplied, and products purchased, and supplied.
1.4 No action will be taken against the practitioner on the grounds of misrepresentation, or the absence of informed consent by me, during the SWWLP.

2. request and authorise the practitioner to prescribe and order all medicines required by me for purpose of the SWWLP from Scriptchem, and for the pharmacy to compound and deliver the prescribed medicine to the physical address of the practitioner on my behalf, for which purpose this request and authority shall constitute my express written consent and authority for the practitioner to contract with the pharmacy on my behalf.

3. confirm that this contract, read with my patient details, and SWWLP documentation, the medicines prescribed, admixed, compounded and supplied, and the products ordered by me from time to time, contains all the agreed terms between the practitioner and me as patient, and no other agreement or promise, oral or written, will be valid, unless reduced to writing and signed by both the practitioner and I.

PATIENT'S SIGNATURE: _____ DATE: _____

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INDEMNITY: SLENDER WONDER MEDICAL WEIGHT LOSS (PTY) LTD

I, the undersigned,

_____

do herewith understand and accept that:

Slender Wonder Medical Weight Loss (Pty) Ltd ("the Company"), any other party (whether or not involved in creating, producing or delivering the Slender Wonder weight loss
products), and any of our group companies and the officers, directors, employees, shareholders or agents of any of them, exclude all liability and responsibility for any amount or kind of loss or damage that may result to a user of the Slender Wonder medical weight loss products and/or programmes or a third party (including without limitation, any direct, indirect, punitive or consequential loss or damages, or any loss of income, profits, use of money, or loss or damages arising from or connected in any way to the Company or the use of the Company's programmes and/or products.

SIGNED AT _____ ON THIS _____ DAY OF _____

NAME:_____ SIGNATURE:_____

WITNESSES: 1. _____

2. _____

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INDEMNITY: PHOTOGRAPHS OF PATIENT

MODEL INDEMNITY FORM – IF PHOTOGRAPHS ARE TAKEN

The undersigned, also known as the model, gives on grounds of his / her signature below, permission to be photographed. Photography entails the following:
Still photography (digital / electronic photos and / or printed photos), and / or video / film or any media, which can be classified as photography. The undersigned agrees to have no claim on the above-mentioned photos and negatives and / or video / film clips as well as oral or written references.
The undersigned will / may not demand or receive remuneration for the permitted / approved use of the above-mentioned photos. The approved use includes printing, material for advertising, the internet / " World Wide Web" or any other media, which the photographer may find appropriate / applicable for the use in all / any National / international markets.

The undersigned agrees to have no claim on any profit / monetary benefit, which may be achieved through the re-sale / distribution of the above-mentioned photos / video / film to any source of Slender Wonder Medical Weight Loss(Pty)Ltd or their agents / providers, for use in all / any National / International markets.

Name:_____

Date:_____

Signature:_____