

**CLARKSON NOTCUTT (INSURANCE BROKER) LTD**

Madison Insurance House, Upper Hill Road  
P.O. Box 30279 - 00100 Nairobi, Kenya.  
Tel: 2731310/1/2/3; 2713770/1/5  
Fax: 2713772  
Email: [clarknot@clarknot.com](mailto:clarknot@clarknot.com)  
Website: [www.clarknot.com](http://www.clarknot.com)

**PRE-ADMISSION AUTHORIZATION**  
*(EMERGENCY ADMISSION / ELECTIVE ADMISSION)*

*This form MUST be completed and Returned / Faxed to Clarkson Notcutt (Insurance Broker) Ltd*

*Fax No.2713772*

Patients Name: \_\_\_\_\_ Age \_\_\_\_\_

Principal member's Name: \_\_\_\_\_

Scheme Name: \_\_\_\_\_

Admitting Hospital: \_\_\_\_\_ Date of Admission \_\_\_\_\_

Diagnosis: \_\_\_\_\_

When was the ailment first diagnosed? \_\_\_\_\_

If pregnancy related state L.M.P \_\_\_\_\_ If C/S, state if first. YES \_\_\_ NO \_\_\_  
If not the first C/S, state which one \_\_\_\_\_

What is the possible cause of the ailment? \_\_\_\_\_

Is the ailment **congenital / malignant / chronic / recurring?**

(Please indicate) \_\_\_\_\_

Has a **HIV Test** been done? **YES/NO** If yes, what are the results? \_\_\_\_\_

Operation required (if any) \_\_\_\_\_

Nature of treatment given & Recommendation \_\_\_\_\_

Estimated cost of treatment \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Signature & stamp \_\_\_\_\_

Date \_\_\_\_\_

*(A full medical report should accompany the hospital invoice /statement on discharge.)  
For any query please contact Clarkson Notcutt Medical Department.  
Emergency No. 0724-261496 OR 0720-621497*