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CHRONIC MEDICINE BENEFIT APPICATION FORM

Completing the chronic medicine application form: Please print using block letters

1. Member to complete section 1 and patient consent and signature section 5
2. Treating doctor to complete section 2,3 4 and doctor declaration and signature section 5
3. Once completed please fax application and copies of supporting results or tests* to 086 210 8743 or e-mail to Chronicmedicine@universal.co.za

SECTION 1: PATIENT DETAILS

Patient surname:				
Patient first name:				
Date of birth / Identity no:		Gender:	M	F
Medical Scheme:				
Medical Scheme Option:		Dependent code:		

Residential address:		Postal address:	
	Postal code:		Postal code:

Telephone no.:	Home	Work	Cell
E-mail:		Fax:	
Occupation:		Student/Scholar:	

How would you like the outcome of the application to be communicated to you? | E-mail | Fax | Tel |

SECTION 2: DOCTOR DETAILS

Doctor's name:		Practice no.:	

Practice address:		
	Postal code:	

Telephone no.:		Fax no.:	
E-mail address:			

SECTION 3: PATIENT'S MEDICAL INFORMATION. (PLEASE PROVIDE INFORMATION RELEVANT TO PATIENT'S CHRONIC CONDITION(S))

Height		Waist circumference			
Weight		BMI			
Blood pressure			Date		
*Blood glucose	Random	Fasting	GTT		*HbA1c
Date					
*Lipogram	Total cholesterol	HDL	LDL		Triglyceride
Date					
*CD4 cell count		*Viral load			
Date					
Microalbuminuria		* Creatinine clearance			
Lung function	*FEV1	*FEV/FVC			
Ejection Fraction		Hysterectomy	Y	N	
Allergies		Is female patient pregnant	Y	N	Expected delivery date

Please indicate if the patient has a history of the following:

Ischaemic heart disease/MI		Familial hyperlipidaemia	
TIA/Stroke		Peripheral vascular disease	

First degree relative with premature heart disease (Female < 65 years/ Male <55 Years) [ ]

Has patient been investigated for TB [ ] Has patient been treated for TB [ ]

- Please include copies of results or reports, initial and latest, where indicated for prompt assessment of the chronic medicine application

SECTION 4: CHRONIC MEDICINE APPLICATION

I wish to register the patient's chronic condition only and am not yet applying for chronic medicine.		New application and/or new medicine		Change in treatment	

Please prescribe according to the formulary. Chronic condition list and Formulary available for lookup on www.universal.co.za

Diagnosis/Chronic conditions/ICD10	Medicine name and strength	Dosage	Number of repeats if different from ongoing

SECTION 5: PATIENT AND DOCTOR CONSENT

Patient

- I understand that my personal and clinical information will be kept confidential
- I give permission for my doctor to state the diagnosis of my condition
- I confirm that the information contained in the application is correct

Patient Signature ____________________ Date D D M M Y Y Y Y

Doctor

- I have verified this application against the scheme chronic formulary and the chronic condition list
- I hereby declare that the information provided is true and correct

Doctor Signature ____________________ Date D D M M Y Y Y Y