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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