BEST med medical scheme

Administered by Sanlam

APPLICATION FOR MEDICINE FOR SPECIFIED SICKNESS CONDITIONS

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Paragraphs 1 to 3 must be completed by the member
Paragraphs 4 to 9 must be completed by a medical practitioner

1. PARTICULARS OF PRINCIPAL MEMBER

Surname and initials: ..... Member number: .....

Address: .....

Birth date: ..... Telephone number:(w) .....

Telephone number:(h) ..... E-mail: .....

Cell phone number: ..... Fax: .....

2. PARTICULARS OF PERSON REQUIRING MEDICATION

Surname and initials: ..... Cell phone number: .....

Birth date: ..... Height: ..... Gender: **M** **F**

Does the patient smoke? **YES** **NO** Weight: ..... Kg

Did the patient smoke previously? **YES** **NO** LMI (BMI): ..... Hysterectomy: **YES** **NO**

E-mail: .....

3. PERMISSION

I hereby give permission to the doctor or any other service provider to state the diagnosis and mention any other information relating to my condition on the form. I understand that this information will remain confidential at all times.

Signature: ..... Date: .....

4. CLINICAL QUESTIONNAIRE: IMPORTANT

a) Please complete all the appropriate parts in the following clinical questionnaire. For medicine used for **Crohn's disease, Rheumatoid arthritis and Ulcerative colitis** an additional questionnaire must be obtained from BESTmed and completed.
b) Medicine application for **Epilepsy** must be accompanied by **EEG report.**
c) Please attach all the requested pathology and medical reports.

A. HYPERTENSION, HYPERLIPIDAEMIA AND DIABETES MELLITUS

Does the patient suffer from any of the following sickness conditions?

SICKNESS CONDITION			
Diabetes type 1		Diabetes type 2	
Micro-albuminurea of GFR < 60 ml/min		Stroke/TIA	
Left ventricular hypertrophy		Heart failure	
Hypertensive retinopathy		Peripheral arterial disease	
Chronic renal disease		Family history of heart attacks	
Familial hyperlipidaemia		Coronary artery disease (eg Angina, Myocardial infarction, Prior artery bypass graft)**	

**Attach medical reports re incidence of coronary artery disease eg Angina.

BLOOD PRESSURE READING	READING	DATE
Current		
Before treatment with drugs for hypertension (if applicable)		

PATHOLOGY TESTS

Attach copies of pathology tests - only if applicable.

SICKNESS CONDITION	TEST	DATE	TEST RESULT
Diabetes mellitus	Fasting blood glucose value		
	HbA1c		
End stage renal failure	s-createnin level		

Hyperlipidemia		***Before treatment:***		**DATE:**			
Total cholesterol		Trigliserides		HDL		LDL	
Hyperlipidemia		***On treatment:***		**DATE:**			
Total cholesterol		Trigliserides		HDL		LDL	

LIFESTYLE CHANGES:	YES	NO	DETAILS
Does the patient follow an exercise programme?			
Special diet?			
Change in weight?			

B. ASTHMA CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND CHRONIC ALLERGIC RHINITIS:

COLS (PS: Please attach copies of the flow volume test results where applicable.) Mark appropriate block:				
Has the patient tested positive for allergy?			Yes	No
Details of positive test results:				
Has the patient consulted a specialist?			Yes	No
Name of specialist: (if applicable)				
Date of last specialist visit:				
Has any sinus operations been performed?			Yes	No
Does the patient have any pulmonary problems?			Yes	No
Patient's age at onset of symptoms (indicate disease e.g. COPD)				
How many times has the patient been admitted for asthma or COPD in the past three years?		0	<3	>3
How many times has the patient required emergency treatment in the past three years?		0	<3	>3
Frequency of oral cortisone used the past year	Never	1 time	3 or more	Chronic

IN THE CASE OF ASTHMA COMPLETE THE FOLLOWING:				
PEF (% of the predicted).		>80%	60-80%	<60%
How often does the patient suffer from an asthma attack?	< 2 / week	2-4 / week	4 / week	Very often
How often does the patient have symptoms during the night?	< 1 / week	2-4 / week	4 / week	Every night

IN THE CASE OF COPD COMPLETE THE FOLLOWING:			
FEVI (% of predicted)	At least 50%	35 - 49%	< 35%
Dyspnoea	Insignificant during activity	Most of the time	Respiratory failure
Does the patient suffer from the following:	Chronic bronchitis	Emphysema	Heart conditions
Details of any heart condition (if applicable).			

C. OSTEOPOROSIS QUESTIONNAIRE

Copies of earliest and latest dexa densitometries must be attached.

What is the patient's complexion and hair colour?	Light	Dark
Does anyone in the patient's family suffer from osteoporosis?	Yes	No
Is patient currently on hormone replacement therapy?	Yes	No
Date of commencement of hormone replacement therapy. Date		
Does the patient have a proven dairy allergy?	Yes	No
If yes, doctor who diagnosed this allergy?		
Details of previous bone fractures or problems.		
Details of oral cortisone therapy, if any.		
Age when hysterectomy was done, if applicable.		

D. PSYCHIATRIC QUESTIONNAIRE

A psychiatrist must complete this application form

Initial diagnosis and date of diagnose	
Current ICD-10 code	

1) CURRENT DIAGNOSIS ACCORDING TO DSM4 CRITERIA :
Axis i :
Axis ii :
Axis iii :
Axis iv :
Axis v :

2) MEDICATION HISTORY FOR PSYCHIATRIC CONDITIONS:		
Date started	Medicine and dosage	Period used and reason for stopping meds

3) HOSPITALISATION HISTORY FOR PSYCHIATRIC CONDITIONS:			
Date	Length of stay	Hospital	Reason for admittance

Psychiatrist ..... Practise nr .....

IMPORTANT:

- Indicate for every ICD10 code on the table if authorisation is applied for on the PRESCRIBED MINIMUM BENEFIT(PMB) or the FORMULARY BENEFIT. (The PMB benefit is only applicable for diseases on the Chronic disease list according to the legislation.)
- Only medicine on the relevant medicine formulary will qualify for the specific benefit.
- The ICD10 code must be correct and to qualify for PMB benefits it must appear on the list according to the legislation.

6. MEDICINE BENEFITS APPLIED FOR

(Please list all the medicine that is used for this specific sickness condition. Authorisation for any other medicine used for this sickness condition expires with this application).

Formulary benefit:
i) Choose medicine on the formulary for specified sickness condition
ii) 15% co-payment

PMB benefit:
i) Choose medicine from the restricted PMB formulary
ii) No co-payment

ICD10 CODE OF CLINICAL CONDITION	FORMULARY BENEFIT	PMB BENEFIT	NAME AND STRENGTH OF MEDICINE PRESCRIBED AND SELECTED FROM THE BESTmed FORMULARY	DIRECTIONS	QUANTITY REQUIRED PER MONTH	HOW LONG HAS PATIENT BEEN ON THIS MEDICATION?	HOW MANY REPEATS ARE REQUIRED?

7. ALL MEDICINES THAT ARE USED ON A REGULAR BASIS. (MEDICINE OTHER THAN THOSE ON THE FORMULARY AND THAT THEREFORE NOT QUALIFY FOR THIS AUTHORISATION.)	8. ANY OTHER FACTORS TO BE TAKEN IN CONSIDERATION E.G. PREGNANCY (GIVE DUE DATE), PORPHYRIA, RENAL FUNCTION IMPAIRMENT AND CONDITIONS TREATED BY OTHER MEDICAL PRACTITIONERS, OR MEDICINE TO WHICH PATIENT IS ALLERGIC.

9. DECLARATION OF ATTENDING DOCTOR

I declare that to the best of my knowledge, all the above information is true and accurate, based on the examinations and tests performed on this patient.

Surname and initials: ..... Cell phone number: .....

Telephone number: ..... E-mail: .....

Discipline: ..... Fax: .....

Doctor's signature ..... Practice number: ..... Date .....