

APPLICATION FORM MEDICINE RISK MANAGEMENT



H E A L T H C A R E F I R S T

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

SCHEME OPTION

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS

E-MAIL ADDRESS

PATIENT DETAILS:

SURNAME

FIRST NAME TITLE

ADDRESS

E-MAIL ADDRESS

TELEPHONE (W) (H)

I authorise my medical practitioner to furnish and/or disclose to the Medicine Management Programme any fact relating to this application as well as any additional information that may be required from time to time. (Remember that your medical practitioner bears the responsibility of prescribing the medication for you, irrespective of the benefit authorised.)

MEMBER'S SIGNATURE _____ DATE

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

TELEPHONE FAX CELL

POSTAL ADDRESS CODE

E-MAIL ADDRESS

PLEASE NOTE THE SPECIAL REQUIREMENTS FOR THE PRESCRIPTION OF THE FOLLOWING MEDICATION/CONDITIONS:

Roaccutane, Diane & Androcur	Dermatologist/Gynaecologist's report
Topical steroids for eczema/psoriasis	Dermatologist's report
Loceryl, Lamisil for fungal infections	Dermatologist's report
Benzodiazepines, hypnotics	Psychiatrist's report
Fosamax, Aredia, Deca-durabolin, Evista (initially, thereafter every 2 years)	Bone density & Specialist's report
Naramig, Imigran, Zomig, Maxalt for migraine	Neurologist's report
Endometriosis	Gynaecologist's report
Lipid disorders	Full lipogram result
Peptic ulcer disease & gastritis (initially plus every 2 years)	Gastroscopy & HP test result
GORD, hiatus hernia	Gastroscopy
Singulair, Seretide.....	Motivation or specialist script

Please note:

- that this is a general guide and that your scheme may not cover all medication/conditions listed above;
- copies of the results/reports must be attached to this Application Form.

