QUALSA
excellence you can trust

WOOLTRU HEALTHCARE

APPLICATION FORM
MEDICINE RISK MANAGEMENT

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

SCHEME _____ OPTION _____

MEMBERSHIP NUMBER _____

SURNAME _____

TITLE _____ INITIALS _____

E-MAIL ADDRESS _____

PATIENT DETAILS:

NAME AND SURNAME _____

TITLE _____ ID NUMBER OR DATE OF BIRTH _____

ADDRESS _____

E-MAIL ADDRESS _____

TELEPHONE _____ _____ (H) _____ _____ (W)

_____ _____ (CELL)

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 D D M M Y Y Y Y

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME _____ INITIALS _____

PRACTICE NUMBER _____ SPECIALITY _____

TELEPHONE _____ _____ FAX _____ _____

CELLPHONE _____ _____

POSTAL ADDRESS _____ CODE _____

E-MAIL ADDRESS _____

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS:

NAME

PRACTICE NUMBER SPECIALITY

CLINICAL EXAMINATION:

MALE/FEMALE ☐ M ☐ F WEIGHT ☐☐☐ kg HEIGHT ☐☐☐ cm BLOOD PRESSURE ☐☐☐ / ☐☐☐

SMOKING: ☐ NEVER ☐ EX-SMOKER ☐ <10 PER DAY ☐ >10 PER DAY

EXERCISE: ☐ NEVER ☐ <1 HOUR PER WEEK ☐ 1-3 HOURS PER WEEK ☐ >3 HOURS PER WEEK

ALLERGIES: ☐ PENICILLIN ☐ ASPIRIN ☐ SULPHONAMIDES ☐☐☐☐☐☐☐☐ OTHER

PLEASE NOTE THAT IN ORDER TO COMPLY WITH THE GOVERNMENT RISK EQUALISATION FUND (REF), THE RECEIPT OF CERTAIN CLINICAL INFORMATION IS MANDATED PRIOR TO THE AUTHORISATION OF CHRONIC MEDICINES. THESE INCLUDE:

- Chronic Obstructive Airways Disease: ..... Lung Function Tests
- Chronic Renal Failure: ..... Creatinine Clearance/Glomerular Filtration Rate
- Haemophilia: ..... Factors VIII and IX blood levels
- Hyperlipidaemia: ..... Lipogram*

IN ADDITION, MEDICINE RISK MANAGEMENT REQUIRES CERTAIN SPECIAL INVESTIGATIONS TO EXPEDITE THE CHRONIC AUTHORISATION PROCESS. THIS INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:

- Long-acting insulin analogues, glitazones: ..... HbA_{1c} and motivation
- Bisphosphonates and other agents for osteoporosis: ..... Bone Mineral Density and motivation
- Angiotensin Receptor Blockers (ARBs): ..... Motivation

* In primary prevention patients requesting lipid-modifying therapy (e.g. statins), reimbursement is reserved for patients with a greater than 20% risk of an acute clinical coronary event within the next 10 years, as calculated by the Framingham Risk Calculation and in accordance with locally and internationally accepted treatment guidelines. Please note that generic simvastatin is the preferred statin in these instances.

Please indicate below where you agree to a generic substitution and provide your preferred medication name. Chronic medicine is subject to generic reference pricing.

MEDICATION PRESCRIBED (Please use block letters)

ICD-10 Code(s)	Detailed diagnosis and date of diagnosis	Name (trade name or generic equivalent)	Generic substitution		Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication started	Type and date of investigation/report
			Yes	No				

MEDICATION STOPPED (Please use block letters)

ICD-10 Code(s)	Diagnosis	Name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication stopped

PRESCRIBED MINIMUM BENEFITS

If your patient has one or more of the following chronic conditions, he/she may qualify for additional services. Please indicate which condition(s) he/she has by placing an "X" next to the applicable condition.

	Addison's Disease		Crohn's Disease		Hypertension
	Asthma		Diabetes Insipidus		Hypothyroidism
	Bipolar Mood Disorder		Diabetes Mellitus Type 1		Multiple Sclerosis
	Bronchiectasis		Diabetes Mellitus Type 2		Parkinson's Disease
	Cardiac Failure		Dysrhythmias		Rheumatoid Arthritis
	Cardiomyopathy Disease		Epilepsy		Schizophrenia
	Chronic Obstructive Pulmonary Disorder		Glaucoma		Systemic Lupus Erythematosus
	Chronic Renal Disease		Haemophilia		Ulcerative Colitis
	Coronary Artery Disease		Hyperlipidaemia		

I hereby acknowledge that the scheme has appointed Qualsa Healthcare (Pty) Ltd as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner.

I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.

Whilst Qualsa undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Qualsa liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

I hereby certify that the information provided is true and correct.

MEMBER'S SIGNATURE

PRESCRIBING DOCTOR'S SIGNATURE

D D M M Y Y Y Y
DATE

MEMBERSHIP NO.

DOCTOR'S PRACTICE NO.

RETURN ADDRESS: MEDICINE RISK MANAGEMENT, PO BOX 15079, VLAEBERG 8018, FAX 021 480 2755, E-MAIL hrmwooltru@qualsa.co.za

A MEMBER OF METROPOLITAN HEALTH GROUP