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bp

APPLICATION FORM
MEDICINE RISK MANAGEMENT

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

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

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 certify that the information provided is true and correct.

MEMBER'S SIGNATURE ____________ PRESCRIBING DOCTOR'S SIGNATURE ____________ DATE D D M M Y Y Y Y

MEMBERSHIP NO. ____________ DOCTOR'S PRACTICE NO. ____________

RETURN ADDRESS: MEDICINE RISK MANAGEMENT, PO BOX 15079, VLAEBERG 8018, TEL 021 480 4610, FAX 021 480 2742

A MEMBER OF METROPOLITAN HEALTH GROUP

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