Application for Disease Management (DM + HIV)

We're about you

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Please note:
In order for the administrator to deliver efficient service to you, please complete all information as required. Print clearly using capital letters. Only one character per block. Leave open one block between words. Mark with an X where necessary.

Member Details

Member name					
Member surname					
Title		Initial		Main member Y / N	
Contact no		Email			
Nationality		Passport no			
Date of birth		Gender M/F		Employment	
Membership no		Dep No		Option	

Additional contact information

Relationship			
Name		Surname	
Contact no		Email	

Main member details (If applicant is a dependant)

Member name		Member surname			
Title		Initial			
Contact no		Email			
Nationality		Passport no			
Date of birth		Gender M/F		Employment	
Chronic medication					

Chronic disease registration

What condition are you registering for?

○ Asthma	○ Cardiac Failure	○ COPD
○ Coronary Artery Disease	○ Diabetes Type 1	○ Diabetes Mellitus Type 2
○ Hyperlipidaemia	○ Hypertension	○ HIV

List of allergies:

Test done confirming the diagnosis *Date:* DD/MM/YYYY

Is the patient currently being treated for tuberculosis? Yes No

If yes, was it reported? Yes No *Date:* DD/MM/YYYY

Weight: *Height:* *Pregnant:* Yes No

Delivery: NVD C-Section *Delivery date:* DD/MM/YYYY

HIV section

When was the HIV infection first diagnosed? DD/MM/YYYY

Type of screening performed *Date:* DD/MM/YYYY

Is the patient currently being treated for tuberculosis? Yes No

If yes, was it reported? Yes No *Date:* DD/MM/YYYY

Have antiretrovirals been started? Yes No

If yes, what regime was started?

HIV treatment

Drug	*Date Treatment Started*	*Date Treatment Ended*	*Duration (Months)*	*Reason for Discontinuation*

Weight: *Height:* *Pregnant:* Yes No

Delivery: NVD C-Section *Delivery date:* DD/MM/YYYY

HIV staging

Stage 1 Stage 2 Stage 3 Stage 4

Stage 1

Generalised lymphadenopathy Yes No If yes, please specify

Stage 2

Unexplained weight loss/gain Yes No If yes, please specify

Persistent fever Yes No If yes, please specify

Mucocutaneous conditions Yes No If yes, please specify

Pulmonary tuberculosis Yes No If yes, please specify

Shingles within the last 5 years Yes No If yes, please specify

Unexplained anaemia, neutropaenia, chronic thrombocytopaenia Yes No If yes, please specify

Stage 3

Diarrhoea	*Yes* *No*	If yes, please specify	
Fevers	*Yes* *No*	If yes, please specify	
Oral infections	*Yes* *No*	If yes, please specify	
Bacterial infections	*Yes* *No*	If yes, please specify	
Ulcerative gingivitis / Periodontitis	*Yes* *No*	If yes, please specify	

Stage 4

HIV wasting syndrom	*Yes* *No*	If yes, please specify	
Neuropathy	*Yes* *No*	If yes, please specify	
Other conditions	*Yes* *No*	If yes, please specify	

Special investigations and results

Date	*Test*	*Results*	*Action Taken*	*Follow Up Date*

HIV and chronic medication required

Condition / Disease – Condition 1

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date *Repeats*

Condition / Disease – Condition 2

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date *Repeats*

Condition / Disease – Condition 3

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date *Repeats*

Condition / Disease – Condition 4

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date *Repeats*

Condition / Disease – Condition 5

Disease and ICD 10

When was it first diagnosed

Doctor

PR No

Telephone no

Email address

Investigations (please ensure all results are attached to the application)

Follow-up test

Script

Start date

Repeats

Doctor declaration

I, (the doctor), _____, herewith confirm that I have examined and/or procured the tests and/or diagnostic investigations referred to the patient/family. I certify that the particulars are to the best of my knowledge and belief, true and accurate. I acknowledge that the Fund and/or administrator will rely on such particulars when making any recommendations regarding the payment of ongoing/ chronic medication.

_____ _____

Signature of doctor *Date*

Patient consent to obtain medical information and test results

I, _____, hereby authorise any doctor, hospital, clinic, laboratory, and/or medical facility in possession of my medical records to disclose any relevant medical and historical information to the case manager of my Fund and/or its administrator, on the understanding that such information will be treated as strictly confidential at all times.

I further agree that this authorisation shall remain valid after my death. I indemnify the Fund and/or its administrator against any claims of whatsoever nature arising from, or in connection with, the disclosure of any medical information or test results in accordance with this authorisation. I confirm and warrant that the information provided in this application form is true, accurate, and complete.

_____ _____

Signature of patient *Date*