We're about you

Oncology motivation

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For office use only

Membership

Filing number

Authorisation number

Membership number | Benefit option | Dependent code

Group reference number

Date of commencement D D M M Y Y Y Y

Notes

Loaded by _____ Approved by _____ Control Officer _____

Date D D M M 2 0 Y Y Date D D M M 2 0 Y Y Date D D M M 2 0 Y Y

Please note *In order for the administrator to deliver efficient service to you, it is imperative that all sections of this application form to be completed in full. Failing this may cause delay in the processing of the application.*

Particulars of patient *(must be completed)*

Membership number | Benefit option: Select a benefit | Dependant code

Title: Mrs | Initials | First name(s)

Surname

Date of birth | Gender: M F

Tel (H) | Tel (W)

Cell | Fax

Email Address

Particulars of principal member *(must be completed)*

Title: Mrs | Initials | First name(s)

Surname

Particulars of doctor *(section 1 to 6 must be completed by the doctor)*

Title: Mrs | Initials | First name(s)

Surname

Practice number | HPCSA/HPCNA number

Tel (W) | Fax

Email

Section 1 Medical history of patient

Date of first diagnosis

Primary site

ICD code

Histology

Grade

Performance status - ECOG scale

Receptors

Date	Previous treatment	Outcomes	Comments

Disease stage T | N | M

Other, please specify

Metases ☐ Lung ☐ Bone ☐ Liver

Other, please specify

Comorbid diseases

Section 2 PMB condition criteria

Description of condition

PMB code

- ☐ Spread to adjacent organ
- ☐ Irreversible/Irreparable damage to organ of origin or other vital organ
- ☐ Evidence of distant, metastatic spread
- ☐ Demonstrated 5 year survival rate for this cancer is greater than 10%

Section 3 Intent and review of treatment

Plan effective date

Treatment intent

Chemotherapy

- ☐ Hormone manipulation
- ☐ Radiotherapy treatment

Other treatments, please specify

SAOC level

In/Out patient

Hospital name

Hospital practice number

Motivation for hospitalisation

Additional comments

Treatment review

Section 4 Treatment for radiotherapy

Provider name - Professional

Practice number - Professional

Provider name - Technical

Practice number - Technical

Radiotherapy/Planning start date

Area of interest

	Code	Quantity	Professional fee	Technical fee	Total
Planning code 1			N$	N$	N$
Planning code 2			N$	N$	N$
Radiation code 1			N$	N$	N$
Radiation code 2			N$	N$	N$
Radiation code 3			N$	N$	N$
Brachy code 1			N$	N$	N$
Brachy code 2			N$	N$	N$
Brachy code 3			N$	N$	N$
		Supporting items cost	N$	N$	Estimated total cost N$

*If **no** technical fees are reflected in this section, please obtain a separate quote from the hospital*

Section 5 Treatment for chemotherapy

Provider name - Professional

Practice number - Professional

Provider name - Facility

Provider name - Drug

Chemotherapy start date

Height | Weight | Body surface

Infusional fee code | Infusional fee quantity | Infusional fee amount N$

Non-infusional fee code | Non-infusional fee quantity | Non-infusional fee amount N$

Number of cycles

Supporting items - Estimate

Drugs - Estimate

Estimated cost per cycle N$

SAOC equivalent codes

Port | Total estimated N$

Drug	NAPPI code	Route	Quantity	Frequency	Cost per cycle

Section 5 Treatment for supporting drugs/isotopes/materials/fluids

Drugs/isotopes/materials/fluids	NAPPI code	Route	Quantity	Frequency	Cost per cycle
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
					N$
Material estimate	**See account**				N$
					N$
			Providers support total		N$
			Radiotherapy support total		N$
			Chemotherapy support total		N$

Signature of principal member

Date

Signature of doctor

Date