

**APPLICATION FOR
MEDICINE FOR SPECIFIED
SICKNESS CONDITIONS**

Paragraphs 1 to 3 must be completed by the member
Paragraphs 4 to 9 must be completed by a medical practitioner

1. PARTICULARS OF PRINCIPAL MEMBER

Surname and initials: Member number:

Address:

Birth date: Telephone number:(w)

Telephone number:(h) E-mail:

Cell phone number: Fax:

2. PARTICULARS OF PERSON REQUIRING MEDICATION

Surname and initials: Cell phone number:

Birth date: Height: Gender: M F

Does the patient smoke? YES NO Weight: Kg

Did the patient smoke previously? YES NO LMI (BMI): Hysterectomy: YES NO

E-mail:

3. PERMISSION

I hereby give permission to the doctor or any other service provider to state the diagnosis and mention any other information relating to my condition on the form. I understand that this information will remain confidential at all times.

Signature: Date:

4. CLINICAL QUESTIONNAIRE: IMPORTANT

- a) Please complete all the appropriate parts in the following clinical questionnaire. For medicine used for **Crohn's disease, Rheumatoid arthritis and Ulcerative colitis** an additional questionnaire must be obtained from BESTmed and completed.
- b) Medicine application for **Epilepsy** must be accompanied by **EEG report**.
- c) **Please attach all the requested pathology and medical reports.**

A. HYPERTENSION, HYPERLIPIDAEMIA AND DIABETES MELLITUS

Does the patient suffer from any of the following sickness conditions?

SICKNESS CONDITION			
Diabetes type 1		Diabetes type 2	
Micro-albuminurea of GFR < 60 ml/min		Stroke/TIA	
Left ventricular hypertrophy		Heart failure	
Hypertensive retinopathy		Peripheral arterial disease	
Chronic renal disease		Family history of heart attacks	
Familial hyperlipidaemia		Coronary artery disease (eg Angina, Myocardial infarction, Prior artery bypass graft)**	

**Attach medical reports re incidence of coronary artery disease eg Angina.

BLOOD PRESSURE READING	READING	DATE
Current		
Before treatment with drugs for hypertension (if applicable)		

PATHOLOGY TESTS

Attach copies of pathology tests - only if applicable.

SICKNESS CONDITION	TEST	DATE	TEST RESULT
Diabetes mellitus	Fasting blood glucose value		
	HbA1c		
End stage renal failure	s-creatinin level		
Hyperlipidemia	<i>Before treatment:</i>	DATE:	
Total cholesterol	Triglycerides	HDL	LDL
Hyperlipidemia	<i>On treatment:</i>	DATE:	
Total cholesterol	Triglycerides	HDL	LDL

LIFESTYLE CHANGES:	YES	NO	DETAILS
Does the patient follow an exercise programme?			
Special diet?			
Change in weight?			

B. ASTHMA CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND CHRONIC ALLERGIC RHINITIS:

COLS (PS: Please attach copies of the flow volume test results where applicable.) Mark appropriate block:				
Has the patient tested positive for allergy?	Yes	No		
Details of positive test results:				
Has the patient consulted a specialist?	Yes	No		
Name of specialist: (if applicable)				
Date of last specialist visit:				
Has any sinus operations been performed?	Yes	No		
Does the patient have any pulmonary problems?	Yes	No		
Patient's age at onset of symptoms (indicate disease e.g. COPD)				
How many times has the patient been admitted for asthma or COPD in the past three years?	0	<3	>3	
How many times has the patient required emergency treatment in the past three years?	0	<3	>3	
Frequency of oral cortisone used the past year	Never	1 time	3 or more	Chronic

IN THE CASE OF ASTHMA COMPLETE THE FOLLOWING:				
PEF (% of the predicted).	>80%	60-80%	<60%	
How often does the patient suffer from an asthma attack?	< 2 / week	2-4 / week	4 / week	Very often
How often does the patient have symptoms during the night?	< 1 / week	2-4 / week	4 / week	Every night

IN THE CASE OF COPD COMPLETE THE FOLLOWING:

FEVI (% of predicted)	At least 50%	35 - 49%	< 35%
Dyspnoea	Insignificant during activity	Most of the time	Respiratory failure
Does the patient suffer from the following:	Chronic bronchitis	Emphysema	Heart conditions
Details of any heart condition (if applicable).			

C. OSTEOPOROSIS QUESTIONNAIRE

Copies of earliest and latest dexa densitometries must be attached.

What is the patient's complexion and hair colour?		Light	Dark
Does anyone in the patient's family suffer from osteoporosis?		Yes	No
Is patient currently on hormone replacement therapy?		Yes	No
Date of commencement of hormone replacement therapy.	Date		
Does the patient have a proven dairy allergy?		Yes	No
If yes, doctor who diagnosed this allergy?			
Details of previous bone fractures or problems.			
Details of oral cortisone therapy, if any.			
Age when hysterectomy was done, if applicable.			

D. PSYCHIATRIC QUESTIONNAIRE

A psychiatrist must complete this application form

Initial diagnosis and date of diagnose	
Current ICD-10 code	

1) CURRENT DIAGNOSIS ACCORDING TO DSM4 CRITERIA :

Axis i :
Axis ii :
Axis iii :
Axis iv :
Axis v :

2) MEDICATION HISTORY FOR PSYCHIATRIC CONDITIONS:

Date started	Medicine and dosage	Period used and reason for stopping meds

3) HOSPITALISATION HISTORY FOR PSYCHIATRIC CONDITIONS:

Date	Length of stay	Hospital	Reason for admittance

Psychiatrist Practise nr

