

Patient:

SECTION C: CLINICAL INFORMATION (to be completed by the doctor where applicable)

NB: Please attach appropriate diagnostic tests that were performed to confirm the Chronic Illness(es) the patient suffers from. e.g. Pathology Results, Bone Density Reports, ECG reports, criteria for Rheumatoid Arthritis.

DIABETES MELLITIS:

- 1. Initial Venous Glucose Result
- 2. HBA1C Result

HYPERTENSION:

- 1. Initial Bloodpressure Reading mmHg
- 2. Latest Bloodpressure Reading mmHg

HYPERLIPIDAEMIA

- 1. Please attach INITIAL Lipogram Report

CARDIOVASCULAR DISEASE:

- 1. Please specify family or personal history of cardiovascular disease

CHRONIC RENAL FAILURE:

- 1. Creatinine Clearance Result
- 2. Please attach other relevant pathology reports for the use of erythropoetin or iron replacement.

GLAUCOMA

- 1. Intra Ocular Pressure Reading L R

RESPIRATORY CONDITIONS: eg Asthma and COPD

- 1. PEF (L/min)
- 2. FEV (L)
- 3. Use of Bronchodilator per day times
- 4. Limitations on daily activities/exercise Y N
- 5. Using Home Oxygen Y N

SCHIZOPHRENIA:

- 1. Please include DSM IV Criteria

SECTION D: PRESCRIPTION WITH ICD-10 DIAGNOSIS CODE

ICD-10 CODE (DIAGNOSIS)	MEDICATION NAME, STRENGTH & DOSAGE	DATE INITIATED	PREVIOUS MEDICATION AND REASON FOR CHANGES

SECTION E: DOCTOR'S DETAILS (Please print in block letters)

SURNAME _____ INITIALS _____ PRACTICE NUMBER _____

SPECIALITY _____

ACKNOWLEDGEMENT BY EXAMINING DOCTOR:

I certify that the particulars hereto are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and/or procured the tests and/or other diagnostic investigations referred to.

DOCTOR'S SIGNATURE: _____ **DATE:** _____