



APPLICATION FORM

PALLIATIVE CARE PROGRAMME

Please note that a referral letter should accompany this application.

PLEASE USE BLOCK LETTERS FOR ALL SECTIONS

1. MEMBER AND PATIENT INFORMATION

TO BE COMPLETED BY THE APPLICANT

MAIN MEMBER DETAILS

Membership number	<input type="text"/>		
Benefit option	<input type="checkbox"/> Network Option	<input type="checkbox"/> Saver Option	<input type="checkbox"/> Comprehensive Option
Title	<input type="text"/>	Initials <input type="text"/>	ID number <input type="text"/>
Full name and surname	<input type="text"/>		
Email address	<input type="text"/>		

PATIENT DETAILS

Dependant code	<input type="text"/>		
Title	<input type="text"/>	Initials <input type="text"/>	ID number <input type="text"/>
Full name and surname	<input type="text"/>		
Contact numbers	<input type="text"/> Home	Work	<input type="text"/>
	<input type="text"/> Cell phone		
Postal address	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>	Postal code	<input type="text"/>
Email address	<input type="text"/>		
Current location	<input type="checkbox"/> Home	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospice <input type="checkbox"/> Care facility

NEXT OF KIN DETAILS

Full name and surname	<input type="text"/>		
Relationship to applicant	<input type="text"/>	Contact number	<input type="text"/>

PATIENT CONSENT

I understand that Wooltru Healthcare Fund and Momentum Health (Pty) Limited, the Administrator, will maintain the confidentiality of my personal information and comply with the Protection of Personal Information Act 4 of 2013 (POPIA) and all existing data protection legislation, when collecting, processing and storing my personal information for the purposes of registration on the Palliative Care Programme.

I understand that:

- Funding for this benefit is subject to meeting benefit entry criteria requirements as determined by the Fund.
- The benefit provides cover for therapy scientifically proven for my condition, which means that not all medication for the condition will automatically be covered.

Membership number

Doctor's practice number

1. MEMBER AND PATIENT INFORMATION (CONTINUED)

TO BE COMPLETED BY THE APPLICANT (CONTINUED)

PATIENT CONSENT (CONTINUED)

- By registering for the benefit, I agree that my condition may be subject to disease management interventions and periodic review and that this may include access to my medical records.
- Funding will only be effective once the Fund receives an application form that is completed in full.
- Payment to the healthcare professional for the completion of this form, on submission of a claim, will be subject to the Fund rules and where the member is a valid and active member at the service date of the claim.
- I agree to my information being used to develop registries. This means that you give permission for us to collect and record information about your condition and treatment. This data will be analysed, evaluated and used to measure clinical outcomes and to make informed funding decisions.
- To ensure that we pay your claims from the correct benefit, any claims from your healthcare providers must include the relevant ICD-10 diagnosis code(s). Please ask your doctor to also include the relevant ICD-10 diagnosis code(s) on the referral form for any pathology and/or radiology tests. This will enable the pathologists and radiologists to also include the relevant ICD-10 diagnosis code(s) on the claims they submit, thus further ensuring that we pay your claims from the correct benefit.

CONSENT FOR PROCESSING MY PERSONAL INFORMATION

1. I hereby acknowledge that Wooltru Healthcare Fund has appointed Momentum Health (Pty) Limited as the administrator of the programme and that any prescribed medical treatment shall be the sole responsibility of my medical practitioner. I understand that the information provided on this form shall be treated as confidential and will not be used or disclosed except for the purpose for which it has been obtained.
2. I hereby give my consent to the Fund, Momentum Health (Pty) Limited and its employees to obtain my, or any of my dependants', special personal information (including general, personal, medical or clinical), whether it relates to the past or future (e.g. health and biometric) from any of my healthcare providers (e.g. pharmacist, pathologist, radiologist, treating doctor and/or specialist) to assess my medical risk, enrol me on the programme and to use such information to my benefit and to undertake managed care interventions related to my chronic condition(s).
3. I understand that this information will be used for the purposes of applying for and assessing my funding request for chronic benefits.
4. I give permission for my healthcare provider to provide the Fund and the administrator with my diagnosis and other relevant clinical information required to review and process my application.
5. I consent to the Fund and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical) to my healthcare provider, to administer the chronic benefits.
6. Whilst Momentum Health (Pty) Limited undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my healthcare provider (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health (Pty) Limited and its employees or the Fund and its trustees, liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I understand and agree that special personal information relevant to my current state of health may be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

I hereby certify that the information provided in this application is true and correct.

Member/patient signature
(or signature of parent/
guardian if patient is under
the age of 18)

Date

DD/MM/YYYY

2. MEDICAL PRACTITIONER'S INFORMATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

Practice number

Initials

Speciality

Surname

Membership number

Doctor's practice number

2. MEDICAL PRACTITIONER'S INFORMATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

DOCTOR DETAILS (CONTINUED)

Contact numbers	<input type="text"/>	Work	Fax	<input type="text"/>
	<input type="text"/>	Cell phone		
Postal address	<input type="text"/>			
	<input type="text"/>			
	<input type="text"/>	Postal code	<input type="text"/>	
Email address	<input type="text"/>			

3. CLINICAL EXAMINATION

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Please provide a brief history of the patient's current illness and treatment:

Please tick the appropriate box below to indicate which areas of concern require specialist palliative care input.

Main reason for referral	
<input type="checkbox"/>	Advanced care planning
<input type="checkbox"/>	Carer support
<input type="checkbox"/>	End-of-life care
<input type="checkbox"/>	Medical and allied medical needs
<input type="checkbox"/>	Psychological support and counselling
<input type="checkbox"/>	Respite for family support
<input type="checkbox"/>	Social assessment
<input type="checkbox"/>	Other <input type="text"/>

Service requested	
<input type="checkbox"/>	Home assessment
<input type="checkbox"/>	Hospice admission
<input type="checkbox"/>	Care at home
<input type="checkbox"/>	Other <input type="text"/>

Membership number

Doctor's practice number

3. CLINICAL EXAMINATION (CONTINUED)

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

Please tick the appropriate box below to indicate which areas of concern require specialist palliative care input.

Stage of disease	
<input type="checkbox"/>	Advanced
<input type="checkbox"/>	Pre-terminal
<input type="checkbox"/>	Unsure

Has any advanced care planning been discussed with the original treating doctor, the patient or their family members?

Yes No

If 'yes', please provide details:

Should you have any queries or wish to discuss your patient's condition or treatment, please contact our palliative care specialist on the details provided below.

Referring doctor's signature	<div style="border: 1px solid black; width: 260px; height: 100px;"></div>	Date	<div style="border: 1px solid black; width: 170px; height: 20px;"></div> DD/MM/YYYY
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Membership number Doctor's practice number

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09/2025

PALLIATIVE CARE PROGRAMME

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