MEDICINE RISK MANAGEMENT APPLICATION

PLEASE USE BLOCK LETTERS THROUGHOUT

TO BE COMPLETED BY THE **APPLICANT**

MEMBER'S DETAILS:

Your option Network ☐ Saver ☐ Comprehensive ☐

Membership number ____ Title ____ Initials ____

Name ____

Surname ____

Email address ____

PATIENT'S DETAILS:

Name and surname ____

Title ____ ID number or date of birth ____

Postal address ____

____ Code ____

Email address ____

Telephone 0__ ____ (W) 0__ ____ (H)

0__ ____ Cell phone

I authorise my medical practitioner to furnish and/or disclose to the Medicine Risk Management Programme any fact relating to this application as well as any additional information that may be required from time to time. (Remember that your medical practitioner bears the responsibility of prescribing the medication to you, irrespective of the benefit authorised).

Member's signature ____ Date D D M M Y Y Y Y

TO BE COMPLETED BY THE **ATTENDING MEDICAL PRACTITIONER**

DOCTOR'S DETAILS:

Surname ____ Initials ____

Practice number ____ Speciality ____

Postal address ____

____ Code ____

Email address ____

Telephone 0__ ____ (W) Fax number 0__ ____

Cell phone 0__ ____

Wondering why we need all of this information and what we do with it? Find the answers in the Woolworths Employee Privacy Notice, which is available on the Risk and Compliance site on Imbizo.

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ASSOCIATED SPECIALIST'S DETAILS:

Surname | | Initials | |

Practice number | | Speciality | |

CLINICAL EXAMINATION:

☐ Male ☐ Female Weight kg Height cm Blood pressure /

Smoking	☐ Never	☐ Ex-smoker	☐ <10 per day	☐ >10 per day
Exercise	☐ Never	☐ <1 hour per week	☐ 1–3 hours per week	☐ >3 hours per week
Allergies	☐ Penicillin	☐ Aspirin	☐ Sulphonamides	☐ Other

The **Medicine Risk Management Programme** requires certain special investigations to expedite the chronic authorisation process. This includes, but is not limited to, the following:

ANGIOTENSIN RECEPTOR BLOCKERS (ARBS):	Motivation
BISPHOSPHATES AND OTHER AGENTS FOR OSTEOPOROSIS:	Bone mineral density and motivation
CHRONIC OBSTRUCTIVE AIRWAYS DISEASE:	Lung function tests
CHRONIC RENAL FAILURE:	Creatinine clearance/glomerular filtration rate
HAEMOPHILIA:	Factors VIII and IX blood levels
HYPERLIPIDAEMIA:	Lipogram*
LONG-ACTING INSULIN ANALOGUES, GLITAZONES:	HbA_{1C} and motivation

* In primary prevention patients requesting lipid-modifying therapy (e.g. statins), reimbursement is reserved for patients with a greater than 20% risk of an acute clinical coronary event within the next 10 years, as calculated by the Framingham Risk Calculation and in accordance with locally and internationally accepted treatment guidelines.

MEDICATION PRESCRIBED – PLEASE USE BLOCK LETTERS

Please indicate below where you agree to a generic substitution and provide your preferred medication name.
Chronic medicine is subject to generic reference pricing.

ICD-10 code/s	Detailed diagnosis and date of diagnosis	Name (trade name or generic equivalent)	Generic substitution		Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication started	Type and date of investigation/ report
			Y	N				
			Y	N				
			Y	N				
			Y	N				
			Y	N				
			Y	N				
			Y	N				

Doctor's practice number | | Speciality | |

PATIENT'S DETAILS:

Membership number of main member | |

Name | |

Surname | |

Date of birth D D M M Y Y Y Y

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MEDICATION STOPPED – PLEASE USE BLOCK LETTERS

ICD-10 code/s	Diagnosis	Name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication stopped

PRESCRIBED MINIMUM BENEFITS

If your patient has one or more of the following chronic conditions, he/she may qualify for additional services.
Please indicate which condition/s he/she has by placing an "**X**" next to the applicable condition.

	Condition		Condition		Condition
	Addison's disease		Crohn's disease		Hypertension
	Asthma		Diabetes insipidus		Hypothyroidism
	Bipolar mood disorder		Diabetes mellitus type 1 and 2		Multiple sclerosis
	Bronchiectasis		Dysrhythmia (irregular heartbeats)		Parkinson's disease
	Cardiac failure		Epilepsy		Rheumatoid arthritis
	Cardiomyopathy disease		Glaucoma		Schizophrenia
	Chronic renal disease		Haemophilia		Systemic lupus erythematosus
	Coronary artery disease		HIV/AIDS		Ulcerative colitis
	Chronic obstructive pulmonary disorder		Hyperlipidaemia		Other

DECLARATION

I hereby acknowledge that the Fund has appointed Momentum Health Solutions (Pty) Ltd 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.

Whilst Momentum Health Solutions undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Fund and my practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Momentum Health Solutions liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to other parties.

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

Member's signature

Membership number | | | | | | | | | | | | | | | |

Date D D M M Y Y Y Y

Prescribing doctor's signature

Doctor's practice number | | | | | | | | | | | | | | | |

Date D D M M Y Y Y Y

Return address: Medicine Risk Management, PO Box 15079, Vlaeberg 8018
Fax: 021 480 2755 **Email:** chronic@wooltruhealthcarefund.co.za

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