QUALSA
excellence you can trust

transmed
MEDICAL FUND

DISEASE MANAGEMENT PROGRAMME ENROLMENT FORM

Eligibility code (for office use only)

GENERAL INFORMATION

TO BE COMPLETED BY THE APPLICANT

MEMBER DETAILS:

Membership number

Surname

Title Initials

E-mail address

PATIENT DETAILS:

Surname

First name Title

Address

E-mail address

Telephone (H) (W)

(CELL)

Preferred time of contact **DAY** Monday | Tuesday | Wednesday | Thursday | Friday

(Please tick) **TIME** 9:00 | 10:00 | 11:00 | 12:00 | 13:00 | 14:00 | 15:00 | 16:00

I authorise my medical practitioner to furnish and/or disclose to Transmed any information relating to this application, as well as any additional information that may be required from time to time.

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

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

Surname Initials

Practice number Telephone

Cell phone Fax

Postal address

Code

E-mail address

ASSOCIATED SPECIALIST DETAILS:

Name

Practice number

Speciality

Eligibility code
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CLINICAL EXAMINATION:

Gender: M F Weight kg Height cm

Circumference: Waist cm Hip cm

(Waist and hip measurements to be omitted in the case of pregnancy)

Smoking: Yes No Stopped: Less than 12 months ago More than 12 months ago

Exercise: Never Less than 1 hour/week 1-3 hours/week More than 3 hours/week

Allergies: Penicillin Aspirin Sulphonamides

Other

CLINICAL INFORMATION: SUPPLY ONLY IF RELEVANT TO YOUR PATIENT

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

Diagnosis (ICD-10 Codes)

Primary . Other . Other .

Other . Other . Other .

Other . Other . Other .

Cardiac Results

BLOOD PRESSURE:

Reading 1 / mmHg Date: D D M M Y Y Y Y

Reading 2 / mmHg Date: D D M M Y Y Y Y

Reading 3 / mmHg Date: D D M M Y Y Y Y

Blood Glucose Results

HbA_{1c}:

Reading 1 % Date: D D M M Y Y Y Y

Reading 2 % Date: D D M M Y Y Y Y

Reading 3 % Date: D D M M Y Y Y Y

BLOOD GLUCOSE:

Reading 1 mmol/l Date: D D M M Y Y Y Y

Reading 2 mmol/l Date: D D M M Y Y Y Y

Reading 3 mmol/l Date: D D M M Y Y Y Y

Respiratory Results

FORCED EXPIRATORY VOLUME:

FEV1%:

Reading 1 % Date: D D M M Y Y Y Y

Reading 2 % Date: D D M M Y Y Y Y

Reading 3 % Date: D D M M Y Y Y Y

PEAK FLOW:

Reading 1 % Date: D D M M Y Y Y Y

Reading 2 % Date: D D M M Y Y Y Y

Reading 3 % Date: D D M M Y Y Y Y

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Lipogram Results

TOTAL CHOLESTEROL:

Reading 1 mmol/l Date: D D M M Y Y Y Y

Reading 2 mmol/l Date: D D M M Y Y Y Y

Reading 3 mmol/l Date: D D M M Y Y Y Y

LOW DENSITY LIPOPROTEINS (LDL):

Reading 1 mmol/l Date: D D M M Y Y Y Y

Reading 2 mmol/l Date: D D M M Y Y Y Y

Reading 3 mmol/l Date: D D M M Y Y Y Y

TRIGLYCERIDES (TG):

Reading 1 mmol/l Date: D D M M Y Y Y Y

Reading 2 mmol/l Date: D D M M Y Y Y Y

Reading 3 mmol/l Date: D D M M Y Y Y Y

An application for chronic medicine can be found below.

CHRONIC MEDICINE APPLICATION

PLEASE NOTE THAT IN ORDER TO COMPLY WITH THE GOVERNMENT RISK EQUALISATION FUND (REF), THE RECEIPT OF CERTAIN CLINICAL INFORMATION IS MANDATORY PRIOR TO THE AUTHORISATION OF CHRONIC MEDICINES. THESE INCLUDE:

- Chronic Obstructive Airways Disease: .....Lung Function Tests
- Chronic Renal Failure: .....Creatinine Clearance/Glomerular Filtration Rate
- Haemophilia: .....Factors VIII and IX blood levels
- Hyperlipidaemia: .....Lipogram*

IN ADDITION, TRANSMED REQUIRES CERTAIN SPECIAL INVESTIGATIONS TO EXPEDITE THE CHRONIC AUTHORISATION PROCESS. THIS INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:

- Long acting insulin analogues, glitazones: .....HbA_{1c} and motivation
- Biphosphates and other agents for osteoporosis: .....Bone Mineral Density and motivation
- Angiotensin Receptor Blockers (ARBs): .....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. Please note that generic simvastatin is the preferred statin in these instances.**

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

MEDICATION PRESCRIBED (please use block letters)

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

Eligibility code
(for office use only)

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.

	Addison's Disease		Crohn's Disease		Hypertension
	Asthma		Diabetes Insipidus		Hypothyroidism
	Bipolar Mood Disorder		Diabetes Mellitus Type 1		Multiple Sclerosis
	Bronchiectasis		Diabetes Mellitus Type 2		Parkinson's Disease
	Cardiac Failure		Dysrhythmias		Rheumatoid Arthritis
	Cardiomyopathy Disease		Epilepsy		Schizophrenia
	Chronic Obstructive Pulmonary Disorder		Glaucoma		Systemic Lupus Erythematosus
	Chronic Renal Disease		Haemophilia		Ulcerative Colitis
	Coronary Artery Disease		Hyperlipidaemia		

I hereby acknowledge that the scheme has appointed Qualsa Healthcare (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 Qualsa undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that my medical scheme and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Qualsa 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

Prescribing doctor's signature

D D M M Y Y Y Y
Date

Membership no.

Doctor's practice no.

RETURN ADDRESS: Transmed Disease Management Programme, PO Box 32931, Braamfontein 2017 or fax 0861 888 113