transmed
MEDICAL FUND

ENROLMENT FORM
INTEGRATED CARE PROGRAMME

GENERAL INFORMATION

TO BE COMPLETED BY THE APPLICANT

MEMBER DETAILS:

Membership number

Surname

Title Initials

Email address

PATIENT DETAILS:

Surname

First name Title

Address

Email address

Telephone (H) (W)

(Cell phone)

Preferred time of contact (Please tick)

Day	Monday	Tuesday	Wednesday	Thursday	Friday			
Time	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

Surname Initials

Practice number Telephone

Fax Cell phone

Postal address

Code

Email address

ASSOCIATED SPECIALIST DETAILS:

Surname Initials

Practice number Speciality

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

CLINICAL EXAMINATION:

Gender ☐ M ☐ F Weight ☐☐☐ kg Height ☐☐☐ cm Waist ☐☐☐ cm Hip ☐☐☐ cm

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

Smoking ☐ Yes ☐ No Stopped ☐ <12 months ago ☐ >12 months ago

Exercise ☐ Never ☐ <1 hour per week ☐ 1-3 hours per week ☐ >3 hours per 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)	DESCRIPTION	DATE OF DIAGNOSIS
Primary:		
Other:		

BLOOD GLUCOSE RESULTS

HbA$_{1C}$

Reading 1 ☐☐☐ % Test date D D M M Y Y Y Y

Reading 2 ☐☐☐ % Test date D D M M Y Y Y Y

Reading 3 ☐☐☐ % Test date D D M M Y Y Y Y

BLOOD GLUCOSE

Reading 1 ☐☐☐ mmol/L Test date D D M M Y Y Y Y

Reading 2 ☐☐☐ mmol/L Test date D D M M Y Y Y Y

Reading 3 ☐☐☐ mmol/L Test date D D M M Y Y Y Y

CARDIAC RESULTS

BLOOD PRESSURE

Reading 1 ☐☐☐ / ☐☐☐ mmHg Test date D D M M Y Y Y Y

Reading 2 ☐☐☐ / ☐☐☐ mmHg Test date D D M M Y Y Y Y

Reading 3 ☐☐☐ / ☐☐☐ mmHg Test date D D M M Y Y Y Y

RESPIRATORY RESULTS

FORCED EXPIRATORY VOLUME(FEV1%)

Reading 1 ☐☐☐ % Test date D D M M Y Y Y Y

Reading 2 ☐☐☐ % Test date D D M M Y Y Y Y

Reading 3 ☐☐☐ % Test date D D M M Y Y Y Y

Membership no. ☐☐☐☐☐☐☐☐☐☐☐☐☐ Doctor's practice no. ☐☐☐☐☐☐☐☐☐☐☐☐

CLINICAL INFORMATION: SUPPLY ONLY IF RELEVANT TO YOUR PATIENT (CONTINUED)

RESPIRATORY RESULTS (CONTINUED)

PEAK FLOW

Reading 1		%	Test date	D D M M Y Y Y Y
Reading 2		%	Test date	D D M M Y Y Y Y
Reading 3		%	Test date	D D M M Y Y Y Y

LIPOGRAM RESULTS

TOTAL CHOLESTEROL

Reading 1		mmol/L	Test date	D D M M Y Y Y Y
Reading 2		mmol/L	Test date	D D M M Y Y Y Y
Reading 3		mmol/L	Test date	D D M M Y Y Y Y

LOW DENSITY LIPOPROTEINS (LDL)

Reading 1		mmol/L	Test date	D D M M Y Y Y Y
Reading 2		mmol/L	Test date	D D M M Y Y Y Y
Reading 3		mmol/L	Test date	D D M M Y Y Y Y

TRIGLYCERIDES (TG)

Reading 1		mmol/L	Test date	D D M M Y Y Y Y
Reading 2		mmol/L	Test date	D D M M Y Y Y Y
Reading 3		mmol/L	Test date	D D M M Y Y Y Y

Additional information relevant to your patient's condition/s:

AN APPLICATION FOR CHRONIC MEDICINE CAN BE FOUND BELOW.

CHRONIC MEDICINE APPLICATION (COMPLETE ONLY IF APPLICABLE)

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.

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

Membership no. Doctor's practice no.

MEDICINE 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

Additional information/motivation:

MEDICINE 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 or she may qualify for additional services. Please indicate which condition/s he or 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		

Membership no. | | | | | | | | | | | | | |

Doctor's practice no. | | | | | | | | | | | | |

PATIENT CONSENT

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that Momentum Health Solutions (Pty) Ltd is the administrator of the programme and that any medical treatment prescribed as well as the general management of my chronic condition/s will be the sole responsibility of my medical practitioners, in consultation with me. Momentum Health Solutions and the Fund and/or employer will accordingly not be held liable for any claims by me or my dependants arising from the implementation of the programme.
3. I hereby give my consent to Momentum Health Solutions, including their agents and medical staff to obtain my special personal information (i.e. health and biometric) from my healthcare providers (pharmacy, pathology, medical doctor and radiology) to assess my medical risk and enrol me on the programme and to use such information to my benefit. I understand and agree that special personal information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
4. I understand that no information regarding my case will be made available to my employer/s or any other person not directly involved in my care.
5. I give my consent to Momentum Health Solutions to electronically store, access, process and retain my special personal information for the purposes set out in this document as may otherwise be required to administer the programme.
6. 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/or employer and 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 special personal information to other parties.
7. I shall be entitled to terminate my participation in the programme at any time with immediate effect on notice to my medical fund, but understand that all benefits that I enjoyed under the programme shall immediately cease and the Fund shall not be obliged to reinstate such benefits at any time thereafter. I understand that the consequences of such a decision will rest with me alone.
8. I acknowledge that, should I not comply with the programme protocols or prescribed treatment, the Fund and/or employer at its sole discretion may elect to exercise its rights and limit my benefits to the prescribed minimum benefits (PMBs), subject to the applicable legislation and the Fund rules.
9. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the programme.
10. I understand and acknowledge that 'consent', for the purposes of this document, means my informed consent, in other words:
    - 10.1 I have read and understood the contents of this document.
    - 10.2 I understand and acknowledge the nature and purpose for which the personal medical information that will be made available to and disclosed, used, processed and retained by the Fund and my healthcare providers, as set out in this consent.
    - 10.3 I have the legal capacity to give my informed consent, in other words, I am over the age of 18 and am able to fully understand and make decisions about my healthcare.

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

Patient's signature ____________________

Date D D M M Y Y Y Y

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

Membership no. | | | | | | | | | | | | | |

Doctor's practice no. | | | | | | | | | | | | | |

06/2021