

LifeSense Disease Management PAEDIATRIC APPLICATION
Strictly confidential



Please complete this form and return it to LifeSense.
Thank you.

Email to: results@lifesense.co.za OR Fax to: 0860 80 49 60



IF ALL DATA MARKED WITH AN * IS NOT COMPLETED, THE APPLICATION WILL NOT BE PROCESSED
THIS APPLICATION MUST BE COMPLETED IRRESPECTIVE OF WHETHER THE MEMBER REQUIRES
TREATMENT OR NOT

FOR OFFICE USE ONLY

REF. NO : _____

CROSS REF. NO : _____

MAIN MEMBER DETAILS

MAIN MEMBER NAME: _____

GENDER:

MALE

☐

FEMALE

☐

ID NUMBER: _____

CHILD'S DETAILS

SURNAME : _____

FIRST NAMES : _____

DATE OF BIRTH:

--	--	--

GENDER:

MALE

☐

FEMALE

☐

BIRTH DELIVERY METHOD: _____

BIRTH PROVINCE: _____

BIRTH WEIGHT: _____

MOTHER'S DETAILS

MOTHER FIRST NAME: _____

MOTHER SURNAME: _____

HIV STATUS OF MOTHER:

REACTIVE

☐

NON-REACTIVE

☐

ANTIRETROVIRAL HISTORY
OR CURRENT THERAPY OF _____

LATEST CD4 COUNT: _____

LATEST VIRAL LOAD COUNT: _____

GUARDIAN DETAILS

GUARDIAN FIRST NAME: _____

GUARDIAN SURNAME: _____

RELATIONSHIP: _____

DATE OF BIRTH:

--	--	--

PHYSICAL ADDRESS: _____

CODE: _____

POSTAL ADDRESS: _____

CODE: _____

TELEPHONE NUMBER HOME: () _____

CELLPHONE NUMBER: _____

TELEPHONE NUMBER WORK: () _____

SMS NUMBER: _____

PREFERRED FOLLOW UP REMINDER:SMS

☐

EMAIL

☐

EMAIL ADDRESS: _____

MEDICAL AID DETAILS

Strictly confidential

MEDICAL AID: _____ MEDICAL AID NUMBER: _____
PLAN OPTION: _____ DEPENDENT CODE: _____

DOCTOR'S DETAILS

PROOF OF IDENTIFICATION MUST BE SIGNED BY EXAMINER

I, THE EXAMINER acknowledge that I have counselled the applicant on the usage of the medication. Should the applicant refuse a generic equivalent, then he/she may be liable for a co-payment as per the schemes rules. I declare that I have taken due and proper care to verify the true identity of the applicant as stated above & have witnessed his/her signature.

NAME: _____
PRACTICE NUMBER: _____ QUALIFICATION: _____
ADDRESS: _____
CODE: _____
TELEPHONE NUMBER: _____ FAX NUMBER: _____
CELL NUMBER: _____ EMAIL ADDRESS: _____

DOCTOR SIGNATURE : _____ DATE: _____

THIS SECTION MUST PLEASE BE READ, UNDERSTOOD AND SIGNED BY THE MEMBER

For registration the child will be required to undergo a physical examination and have blood tests taken every 16-20 weeks and only on request of the case manager. If there are any queries please do not hesitate to ask your doctor doing this examination about any of these tests.

I, THE MEMBER acknowledge that the examiner has explained the usage of the medication. I, THE MEMBER acknowledge that my child is HIV positive and consent to the use of the appropriate HIV/AIDS medication prescribed by the treating service provider. I the member acknowledge that I will be responsible for any co-payment that may be imposed as per scheme rules.

I _____ the member / guardian understand that in order for the payment of services to the doctor or service provider, the medical aid fund will need to know my identity. I hereby consent to the above procedures. I agree that the medical information relevant to the child's HIV infection may be used for purposes of scientific, epidemiological and/or financial analysis without disclosure of names and that LifeSense may send medical information to the treating doctor and medical aid if required. LifeSense and your medical scheme, adhere to the confidentiality as laid out by the Health Professional Council of South Africa (HPCSA). All personal information collected will be stored in accordance with Protection of Personal Information (POPI) ACT.

MEDICATION DELIVERY ADDRESS

PREFERRED DELIVERY: DOCTOR ☐ HOME ☐ WORK ☐ POST OFFICE ☐

* DOCTOR'S ROOMS OR
POST OFFICE :

CODE: _____

MEDICAL HISTORY

Strictly confidential

* ICD 10 CODE: _____ * DATE FIRST HIV POSITIVE: _____

HAS THE PATIENT EVER HAD ONE OR MORE AIDS DEFINING ILLNESSES? YES ☐ NO ☐

* DOES THE PATIENT HAVE ANY DRUG ALLERGIES? _____

* PLEASE LIST ANY OTHER ILLNESSES OR CHRONIC CONDITIONS? _____

* PLEASE LIST CHRONIC TREATMENT: _____

* HEIGHT cm: _____ * WEIGHT kg: _____

TREATMENT DETAILS

* PREVIOUS AND OR CURRENT HIV TREATMENT

MEDICATION	FROM DATE	TO DATE
_____	_____	_____
_____	_____	_____

* PLEASE LIST ANY TREATMENT REGIMEN SUGGESTED - OR GENERIC EQUIVALENT: _____

SEROLOGICAL TESTS

URINE DIPSTICK: _____ TB SCREENING TEST PERFORMED YES ☐ NO ☐

RESULT POSITIVE ☐ NEGATIVE ☐

TB MEDICATION _____

DATE SEROLOGICAL TEST WAS DONE	
LABORATORY	
REQUISITION NUMBER	
SEROLOGY TEST	RESULT
* FBC	
* Platelets	
* CD4 COUNT	
* VIRAL LOAD	
* ALT	
* AST	
Urea only	
Creatinine only	
Bilirubin Total	
Bilirubin Direct	

THESE ARE THE ONLY TESTS COVERED UNDER THE B24 CHRONIC BENEFIT

Genotyping requires prior authorisation - Tarrif code 4766

Please attach an original script for all ARV and prophylactic medication.

MEMBER / GUARDIAN ID NUMBER : _____ CHILD'S ID NUMBER : _____

PLACE: _____

MEMBER / GUARDIAN SIGNATURE : _____ DATE: _____