APPLICATION FORM
MEDICINE RISK MANAGEMENT

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

Option

Membership number

Surname

Title Initials

Email address

PATIENT DETAILS:

Name and surname

Title ID number or date of birth

Address

Email address

Telephone (H) (W)

(Cell)

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 for 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 DETAILS:

Surname Initials

Practice number

Speciality

Telephone Fax

Cellphone

Postal address

Code

Email address

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER (CONTINUED)

ASSOCIATED SPECIALIST DETAILS:

Name

Practice number

Speciality

CLINICAL EXAMINATION:

Gender ☐ M ☐ F 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

Please note that in order to comply with the Government Risk Equalisation Fund (REF), the receipt of certain clinical information is mandated 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, Medicine Risk Management 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
» Bisphosphonates 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)	Generic substitution		Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication started	Type and date of investigation/report
			Yes	No				

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

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

I hereby acknowledge that the Society has appointed Metropolitan Health Risk Management (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.

I hereby give my consent to Metropolitan Health Risk Management and its 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.

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

I understand and accept that during my membership of the Society both Special Personal Information relating to me and my dependants, as beneficiaries, will be disclosed to the Society, as well as the Administrator and/or managed care provider and form part of the records of the Society.

Continued overleaf »

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

I hereby authorise the Society and its Administrator and/or managed care provider to provide such Special Personal Information relating to me and/or my dependants under the age of 18, including any authorisations, to the Society's contracted designated service providers and/or other third parties, provided that such information will only be used for the purposes of:

» considering this application;
» the payment of any claims relating to benefits payable under the Society rules;
» the granting of any approvals and/or authorisations, including those relating to hospital admission and/or the participation in any managed care programmes which the Society has contracted to be provided to beneficiaries.

I also undertake to take all such steps as to ensure that any dependant over the age of 18, or younger, as may be required by law, also provide their written consent to the disclosure of any such information.

This consent is provided on the clear understanding that:

1. the designated service providers and/or any third parties will be bound by the same confidentiality agreement as exists between the Society and its Administrator and/or its managed care provider, as well as their employees relating to the confidentiality of such information;
2. this information will be provided solely for the purposes of providing relevant healthcare and/or managed healthcare services and/or benefits to myself and/or my dependants;
3. wherever reasonably possible, such information is to be anonymised or encrypted.

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. | | | | | | | | | | | | |

08/14 L4085

Return Address: Medicine Risk Management, PO Box 15079, Vlaeberg 8018
Tel 0800 001 607 **Fax** 021 480 2742
PHARMACIST-ON-LINE: Tel 0861 888 124 (for doctors/pharmacists only)