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APPLICATION FORM 2012: CHRONIC DISEASE MANAGEMENT PROGRAMME

Please note:

- **Incomplete application forms will not be processed.**
- The doctor's fee for completion of this form will be reimbursed from your medical savings account or day to day, subject to availability of funds.

Section 1 to be completed by the Principal member and Section 2 to be completed by the patient.

SECTION 1 – MAIN MEMBER INFORMATION

Membership number:	Surname:	
Initials:	Title:	
PLAN CHOSEN FOR 2012: (tick chosen option) **Premium:**	**Silver:**	**Select:**
Date of Birth:		
Postal Address:		
Telephone numbers	Work:	Home:
	Fax:	Cellular:
E-mail address:		

SECTION 2 – PATIENT INFORMATION

Membership number:	**Surname:**	
Initials:	**Title:**	
PLAN CHOSEN FOR 2012: (tick chosen option) Premium:	**Silver:**	**Select:**
Date of Birth:		

I_____ do hereby give permission for my doctor to divulge my diagnosis and any other relevant clinical information to Cape Medical Plan. I understand that benefits for the treatment of my condition/s will be subject to disease management interventions and that non-compliance with the medication and/or protocol may lead to withdrawal of the chronic benefit and related treatments/ hospitalisations.

Patient's Signature:	**Date:**

Sections 3 - 6 to be completed by the attending medical practitioner

SECTION 3 – DOCTOR'S DETAILS

Doctor's surname:		Initials:
BHF practice number:		
Telephone numbers:	Practice:	
	Fax:	
E-mail address:		

SECTION 4 – CARDIOVASCULAR DETAILS

Male/Female:				Weight: kg	
Height: cm				Smoking:	Yes: / No:
Blood Pressure:					
How many times per week does patient exercise:					
Does your patient suffer from any of the following / or had any of the following events:					
Left ventricular hypertrophy:		Stroke/TIA:		Angiogram with stent	
Angina:		Chronic Renal Disease:		Prior CABG (Coronary Artery Bypass Graft):	
Myocardial Infarction:		Peripheral Arterial Disease:		Heart Failure:	
If YES, please provide details:					

SECTION 5 - APPLICATION FOR HYPERTENSION (if applicable)

This section must be completed for all patients re-authorising for Hypertension

Complete for Hypertension diagnosed in the last year and for all newly diagnosed patients:

Initial Blood Pressure reading	mm Hg	Date:
Current Blood Pressure reading	mm Hg	Date:

SECTION 6 - CURRENT MEDICATION REQUIRED

Please note that the following commonly requested medicines are excluded from Cape Medical Plan's Chronic Benefit: Vitamin and mineral preparations, antibiotics, homeopathic medicines, mucolytics, antihistamines, hypnotics as well as medication for any other chronic condition for which Cape Medical Plan does not currently provide a chronic benefit.

Diagnosis	Date when condition was first diagnosed	ICD 10 code	Medication Name	Active Ingredient	Strength (eg 50mg)	Doses/day

If necessary, do you have any additional information that you wish the Scheme to consider?

Prescribing Doctor's Information:

Full Name: _____

Signature:	**Date:**