

CHRONIC MEDICATION APPLICATION



All information received in terms of this application will be treated as confidential

Patient's Name _____ Call Centre: **0860 102 182**
(Doctor to complete this page) Fax: **(021) 673 1815**

DOCTOR'S DETAILS

Surname _____ Initials _____ Qualifying degree _____

Practice Number _____ SAMDC Reg Number _____

Delivery Address _____
 _____ Code _____

Telephone Number _____ Fax Number _____

Medical Scheme Name _____ Medical Scheme Number _____

New Application Update Change in Treatment

DIAGNOSIS	NAME OF MEDICINE AND STRENGTH	DIRECTIONS

CareCross requires a copy of the first and latest Lipogram, and risk Evaluation form, where applicable, to prevent a delay in the assessment of the application.

Declaration by Doctor

I have verified this application against the Medicine List as well as the List of Exclusions in terms of the CareCross Benefit.
 I agree to generic substitution, where a cost effective, less expensive alternative exists.
 I hereby declare that the information provided is true and correct.

 Signature

 Date

MEMBER DETAILS

First Name _____ Surname _____ Title _____

Membership Number _____ Medical Scheme Name _____

Option _____

PATIENT DETAIL

First Name _____ Surname _____ Title _____

Date of Birth _____ Dependant Code _____

Postal Address _____

_____ Code _____

Telephone Number (H) _____ (W) _____ Fax Number _____

PATIENT MEDICAL HISTORY

Gender _____ Age _____ Weight _____ Height _____ Blood Pressure _____

Please tick:

Heart Disease Y N

Bypass Surgery Y N

Previous Myocardial Infarct Y N

TIA Y N

Other Major Disease Y N

Diabetes Y N

Smoker Y N

Operations 1. _____

Ex Smoker Y N

2. _____

Environmental Allergies

Medicine Allergies

1. _____

1. _____

2. _____

2. _____

MEDICINE SUPPLIER DETAILS

Name _____ Telephone _____ Fax _____

Delivery Address _____

_____ Code _____

Declaration by Patient

I hereby authorise my Doctor to furnish and/or disclose any fact to this application, and understand that the application is subject to the Chronic Medicine Formulary as well as the List of Exclusions in terms of the CareCross Benefit.

Signature

Date