CHRONIC MEDICATION APPLICATION

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

HOW TO APPLY FOR CHRONIC MEDICATION

1. This application can only be used for members on the Topmed Network option.
2. Visit your Topmed Network Provider (General Practitioner).
3. Complete Patient Information block and sign.
4. Ask your Topmed Network Provider to complete this application form.
5. Fax the completed form 086 604 9930 or email chronic@topmedms.co.za
6. Please ensure that the medical history information is completed.
7. Only complete the Questionnaires that apply to your patient's diagnosis.

PATIENT INFORMATION (To be completed by Patient)

Member Number: _____Patient Date of Birth:_____

Dependant Code: _____Patient Name: _____Surname: _____

Patient Tel No: (W)_____(H)_____Cell Number: _____

Email _____

Delivery Address for medication (only complete if delivery is required):

_____

_____

_____

I understand that Topmed Medical Scheme requires access to personal information in order to make decisions about funding of my proposed treatment. Unless otherwise stated, I hereby authorise Dr. _____ to provide Topmed Medical Scheme with any relevant and appropriate medical information regarding myself as they may require. I understand that this information will be treated in the strictest confidence and will be made available only to the Medical Advisors, Pre-authorisation and Nurse Administrator.

Patient Signature: _____

Date: _____

DOCTOR TO COMPLETE THE FOLLOWING INFORMATION

Doctor Name and Surname: _____ Practice No:_____

Contact Telephone No:_____ Email address:_____

PATIENT MEDICAL HISTORY

Gender: Male / Female Age: _____ Weight: _____kgs Height:_____m

Smoker: Yes/No Ex-smoker: Yes/No (if yes, when did patient last smoke?)_____

Please confirm if patient has any of the following medical conditions? Mark with an X where applicable:

MEDICAL CONDITIONS					
Diabetes				**Cardiac Disease (Please specify diagnosis)**	
Type 1				Coronary artery disease,	
Type 2				Valve disease,	
Insulin Dependent				Cardiac failure	
Non-Insulin Dependent				Arryhthmia (e.g. flutter/ fibrillation)	
Gestational diabetes				**Dyslipidaemia /Lipid abnormalities**	
Diabetic retinopathy				Familial /Genetic	
Neuropathy or peripheral vascular disease				Pure or isolated hypercholesterolemia	
Stroke / TIA				Pure or isolated hypertriglyceridemia	
Ischaemic				Mixed or combined hyperlipidemias	
Haemorrhagic				Secondary	
Chronic renal disease				**Hypertension**	
Dialysis/Chronic renal failure				Hypertensive retinopathy	
Hypertensive renal disease				Essential	
Diabetic renal disease				Secondary	
Other – nephrotic syndrome, autoimmune etc				Gestational hypertension/eclampsia	
Family history of heart disease including hypertension, coronary artery disease and high cholesterol in first degree relative (mother, father, sibling) If yes, please state relationship current age or if deceased, age at death if death was related to heart disease				Previous Cardiac procedure or signifcant acute event related to chronic conditions NB: Please attach all relevant medical reports.	
Relative	**Alive**	**Deceased**	**Age**	Myocardial infarction,	
				Coronary artery bypass graft	
				Angioplasty/stents	
				Pacemakers	
				Valve replacement	
				Aneurysm repair	

HYPERTENSION QUESTIONNAIRE

BLOOD PRESSURE READING		DATE
At diagnosis		
Current		

HYPERLIPIDAEMIA QUESTIONNAIRE

BASELINE LIPOGRAM VALUES								TEST DATE
Total Cholesterol		Triglycerides		HDL		LDL		
LIPOGRAM VALUES ON TREATMENT								**TEST DATE**
Total Cholesterol		Triglycerides		HDL		LDL		

Does the patient suffer from any of the following conditions?	Please select		Details
Hypo- or Hyperthyroidism?	Yes	No	
History of Peripheral artery disease?	Yes	No	
Were any lifestyle changes made?	Yes	No	
• Does the patient follow an exercise programme?	Yes	No	
• Does the patient follow a special diet?	Yes	No	
• Were there any changes in weight?	Yes	No	

DIABETES MELLITUS QUESTIONNAIRE

Is the patient newly diagnosed with diabetes?	Yes	No	Type of Diabetes		Type 1	Type 2
Baseline pathology values						
Fasting blood glucose			HbA1c		Date of Test	
Most recent pathology results						
Fasting blood glucose			HbA1c		Date of Test	

HYPOTHYROIDISM QUESTIONNAIRE

Please attach the initial or diagnostic laboratory results that confirm the diagnosis of hypothyroidism, including TSH and T4 levels

Please indicate whether your patient has had a thyroidectomy	Yes	No
Please indicate whether your patient has been treated with radioactive iodine	Yes	No
Please indicate whether your patient has been diagnosed with Hashimoto's thyroiditis	Yes	No

RHEUMATOID ARTHRITIS QUESTIONNAIRE

Treatment with biologicals must be motivated as per SARAA guidelines. Specialist referral subject to pre-authorisation

Please advise on previous DMARD therapy

Name of Medicine	Dosage	Duration of therapy	Reason why stopped (if applicable)

Please mark the appropriate block

Symptoms					
Symmetry		>3 joint groups		Stiffness > 1 hour	
SDAI count		CRP Units		Hand joints affected	
Number of swollen joints		Number of tender joints			
Functional Impairment					
Class 1 : No restriction		Class 2: Discomfort		Class 3: Self care	
Class 4: Dependent					

RENAL QUESTIONNAIRE

Please attach latest pathology results

Please indicate the following:

Stage		eGFR		Creatinine		Hb	
Please confirm if patient is currently receiving dialysis						Yes	No
Is the patient on the Transplant list						Yes	No

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) QUESTIONNAIRE

Results of lung function test must be attached

Date when COPD was diagnosed				
How many times was the patient hospitalised for COPD in the past 3 years?		0	<3	>3
How many times did the patient receive emergency treatment for COPD in the past 3 years?		0	<3	>3
Frequency of oral cortisone treatment in the past year?	Never	Once	3 or >	Chronic
Date of lung function test				
FEV1 (% of calculated), predicted	≥ 80%	79-50%	49-30%	<30%
FEV1/FVC value of the report				

FEV1 post-bronchodilator value of the report					
Does the patient suffer from any of the following conditions	Heart condition	Yes	No	ICD 10	
	Respiratory Failure	Yes	No	ICD 10	

PSYCHIATRIC QUESTIONNAIRE

Primary Diagnosis (Please select)	Bipolar Mood Disorder	Schizophrenia
ICD 10 code		
Secondary Diagnosis		
Co-morbidities/Other chronic conditions		
Social measures		
Estimated GAF score		

Hospitalisation history for psychiatric conditions

Date	Length of stay	Hospital	Reason for admission

TREATMENT PRESCRIBED

Please ensure that the ICD 10 code is provided. Without the ICD 10 code the application can't be processed

ICD 10 Code	**Name of medication and strength**	**Dosage**

Doctor Signature:_____ Date:_____