Universal Healthcare Provider Network, a division of Universal Care
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Email: chronicmedicine@universal.co.za / www.universal.co.za

UNIVERSAL CHRONIC MEDICINE APPLICATION FORM

Completing the chronic medicine application form: Please print using block letters
1. Member/Patient to complete section 2 and patient consent and signature section 6
2. Treating doctor to complete section1,3 4,5 and doctor declaration and signature section 6
3. Once completed please email the completed application form to: **Chronicmedicine@universal.co.za**

1. PROVIDER DETAILS

Practice name: | Practice number:
Office Tel: | Email:
Physical address:
Postal code:
Postal address:
Postal code:

2. PATIENT DETAILS

Surname: | First name/s:
Date of birth: (D D M M Y Y Y Y) | Gender: M F | Age:
Telephone no.: (H): | (W):
Cellphone number: | E-mail address:
Physical address:
Postal code:
Postal address:
Postal code:
Occupation: | Type of employment:
How would you prefer the outcome of the application status to be communicated to you? E-mail: Telephonically:

3. MEDICAL AID DETAILS

Medical Scheme: | Medical Scheme Option:
Member/Policy /ID number: | Dependent code:

4. PATIENT'S MEDICAL INFORMATION. (PLEASE PROVIDE INFORMATION RELEVANT TO PATIENT'S CHRONIC CONDITION/S)

Height (cm): | Weight (kg): | Waist circumference (cm):
BMI: | Blood pressure:
Date: (D D M M Y Y Y Y)

***Blood glucose:**
Random: | Fasting: | GTT: | *HbA1c:
Date: (D D M M Y Y Y Y)

***Lipogram:**
Total cholesterol: | HDL: | LDL: | Triglyceride:
Date: (D D M M Y Y Y Y)

*CD4 Cell Count: | *Viral Load:
Microalbuminuria: | *Creatinine clearance:
Date: (D D M M Y Y Y Y)

Lung function:

*FEVI: *FEV/FVC:

Ejection Fraction: Hysterectomy: (Y) (N) Pregnant: (Y) (N)

Expected Delivery Date: D D M M Y Y Y Y

Allergies:

Please indicate if the patient has a history of the following:

Ischaemic heart disease/MI: Familial hyperlipidaemia:

TIA/Stroke: Peripheral vascular disease:

First degree relative with premature heart disease (Female < 65 years/ Male <55 Years)

Has patient been investigated for TB: (Y) (N) Has patient been treated for TB: (Y) (N)

5. CHRONIC MEDICINE APPLICATION (BLOCK LETTERS)

Registration of chronic condition only New application and/or new medicine Change in treatment

Please prescribe according to the formulary. Chronic condition list and Formulary available for lookup on www.universal.co.za

Diagnosis / Chronic Conditions/ ICD10 code	Medicine name and strength	Dosage	Number of repeats if different from ongoing

6. PATIENT AND DOCTOR CONSENT

Patient

- I understand that my personal and clinical information will be kept confidential.
- I give permission for my doctor to state the diagnosis of my condition.
- I confirm that the information contained in the application is correct.

Patient's signature

D D M M Y Y Y Y

DATE

Doctor

- I have verified this application against the scheme chronic formulary and the chronic condition list.
- I hereby declare that the information provided is true and correct.

Doctor signature

D D M M Y Y Y Y

DATE