

APPLICATION FORM

MEDICINE RISK MANAGEMENT

TO BE COMPLETED BY APPLICANT

MEMBER DETAILS:

OPTION

MEMBERSHIP NUMBER

SURNAME

TITLE INITIALS

E-MAIL ADDRESS

PATIENT DETAILS:

NAME AND SURNAME

TITLE ID NUMBER OR DATE OF BIRTH

ADDRESS

E-MAIL ADDRESS

TELEPHONE (H) (W)
 (CELL)

I authorise my medical practitioner to furnish and/or disclose to the Medicine 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

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS:

SURNAME INITIALS

PRACTICE NUMBER SPECIALITY

TELEPHONE FAX

CELLPHONE

POSTAL ADDRESS CODE

E-MAIL ADDRESS

ASSOCIATED SPECIALIST DETAILS:

NAME

PRACTICE NUMBER SPECIALITY

CLINICAL EXAMINATION:

MALE/FEMALE 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

