LifeSense Disease Management ADULT APPLICATION

Strictly confidential

Please complete this form and return it to LifeSense.
Thank you.
Email to: results@lifesense.co.za OR Fax to: 0860 80 49 60

Winner FMR Diamond Arrow Award

IF ALL DATA MARKED WITH AN * IS NOT COMPLETED, THE APPLICATION WILL NOT BE PROCESSED
THIS APPLICATION MUST BE COMPLETED IRRESPECTIVE OF WHETHER THE MEMBER REQUIRES TREATMENT OR NOT

FOR OFFICE USE ONLY

REF. NO : _____ **CROSS REF. NO :** _____

MAIN MEMBER DETAILS

MAIN MEMBER NAME: _____

GENDER: MALE ☐ FEMALE ☐ MAIN MEMBER ID NUMBER: _____

APPLICANT DETAILS

SURNAME : _____

FIRST NAMES : _____

DATE OF BIRTH: _____ GENDER: MALE ☐ FEMALE ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW (ER) ☐ COMMON LAW ☐

EMPLOYER DETAILS

EMPLOYER NAME: _____

JOB DESCRIPTION: _____ PROVINCE: _____

TICK WHICH APPLICABLE: DAY SHIFT ☐ NIGHT SHIFT ☐

MEDICAL AID DETAILS

MEDICAL AID : _____ MEDICAL AID NUMBER : _____

PLAN OPTION : _____ DEPENDENT CODE : _____

NEXT OF KIN DETAILS

NAME : _____ RELATIONSHIP _____

CONTACT NO. _____ NEXT OF KIN IS AWARE OF STATUS: ☐

APPLICANT CONTACT DETAILS

PHYSICAL ADDRESS: _____

_____

_____ CODE: _____

POSTAL ADDRESS: _____

_____

CODE: _____

TELEPHONE NUMBER HOME: ( ) _____ CELLPHONE NUMBER: _____

TELEPHONE NUMBER WORK: ( ) _____ SMS NUMBER: _____

PREFERRED FOLLOW UP REMINDER: SMS ☐ EMAIL ☐ EMAIL ADDRESS: _____

continue overleaf

DOCTOR'S DETAILS

Strictly confidential

PROOF OF IDENTIFICATION MUST BE SIGNED BY EXAMINER

I, THE EXAMINER acknowledge that I have counselled the applicant on the usage of the medication and should the applicant default in taking the medication, it could lead to multi-drug resistant virus. Should the applicant refuse a generic equivalent, then he/she may be liable for a co-payment as per the schemes rules. I declare that I have taken due and proper care to verify the true identity of the applicant as stated above & have witnessed his/her signature.

NAME: _____

PRACTICE NUMBER: _____ QUALIFICATION: _____

ADDRESS: _____

_____

CODE: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

CELL NUMBER: _____ EMAIL ADDRESS: _____

DOCTOR SIGNATURE : _____ DATE: _____

THIS SECTION MUST PLEASE BE READ, UNDERSTOOD AND SIGNED BY THE APPLICANT

Your participation in this programme is one of the most important ways to keep you well. For registration you will be required to answer medical questions, undergo a physical examination and have blood tests taken every 16 - 20 weeks and only on request of the case manager. If you have any queries please do not hesitate to ask your doctor doing this examination about any of these tests.

I, THE APPLICANT acknowledge that the examiner has explained the usage of the medication to me, if applicable. I, THE APPLICANT acknowledge that I am HIV positive and consent to the use of the appropriate HIV/AIDS medication prescribed by the treating service provider, if applicable. I the applicant acknowledge that I will be responsible for any co-payment that may be imposed as per scheme rules.

I _____ understand that in order for the payment of services to the doctor or service provider, the medical aid fund will need to know my identity. I hereby consent to the above procedures. I agree that the medical information relevant to my HIV infection may be used for purposes of scientific, epidemiological and/or financial analysis without disclosure of my name and that LifeSense may send medical information to the treating doctor and medical aid if required. LifeSense and your medical scheme, adhere to the confidentiality as laid out by the Health Professional Council of South Africa (HPCSA). All personal information collected will be stored in accordance with Protection of Personal Information (POPI) ACT.

MEDICATION DELIVERY ADDRESS

PREFERRED DELIVERY: DOCTOR ☐ HOME ☐ WORK ☐ POST OFFICE ☐ NOT APPLICABLE ☐

DELIVERY ADDRESS: _____

_____

CODE: _____

MEDICAL HISTORY

ICD10 code: _____

* DATE FIRST HIV POSITIVE: _____

* HAS THE PATIENT EVER HAD AIDS DEFINING ILLNESSES? _____

* DOES THE PATIENT HAVE ANY DRUG ALLERGIES? _____

* PLEASE LIST ANY OTHER ILLNESSES OR CHRONIC CONDITIONS? _____

* PLEASE LIST CHRONIC TREATMENT: _____

WHAT IS THE STATUS OF YOUR PARTNER? POSITIVE ☐ NEGATIVE ☐ UNKNOWN ☐

IF POSITIVE IS YOUR PARTNER ON ARV'S? YES ☐ NO ☐

* HEIGHT cm: _____ * WEIGHT kg: _____

continue overleaf

TREATMENT DETAILS

Strictly confidential

*** PREVIOUS AND OR CURRENT HIV TREATMENT**

MEDICATION FROM DATE TO DATE

_____ _____ _____

_____ _____ _____

*** PLEASE LIST ANY TREATMENT REGIMEN SUGGESTED - OR GENERIC EQUIVALENT:**

_____

_____

SEROLOGICAL TESTS

URINE DIPSTICK: _____ *** PREGNANCY TEST** POSITIVE ☐ NEGATIVE ☐

LMP: _____ **EDD:** _____

DATE SEROLOGICAL TEST WAS DONE	
LABORATORY	
REQUISITION NUMBER	
SEROLOGY TEST	**RESULT**
*** FBC**	
*** Platelets**	
*** CD4 COUNT**	
*** VIRAL LOAD**	
*** ALT**	
*** AST**	
Urea only	
Creatinine only	
Bilirubin Total	
Bilirubin Direct	

THESE ARE THE ONLY TESTS COVERED UNDER THE B24 CHRONIC BENEFIT

Genotyping requires prior authorisation - Tarrif code: 4766

SEROLOGICAL TESTS

TB SCREENING TEST PERFORMED YES ☐ NO ☐

RESULT POSITIVE ☐ NEGATIVE ☐

TB MEDICATION _____

_____

Please attach an original script for all ARV and prophylactic medication

ID NUMBER: _____

PLACE: _____

APPLICANT'S SIGNATURE : _____ DATE: _____