LifeSense Disease Management PAEDIATRIC 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 ☐ ID NUMBER: _____

CHILD'S DETAILS

SURNAME : _____

FIRST NAMES : _____

DATE OF BIRTH: ☐☐ ☐☐ ☐☐ GENDER: MALE ☐ FEMALE ☐

BIRTH DELIVERY METHOD: _____

BIRTH PROVINCE: _____ BIRTH WEIGHT: _____

MOTHER'S DETAILS

MOTHER FIRST NAME: _____ MOTHER SURNAME: _____

HIV STATUS OF MOTHER: REACTIVE ☐ NON-REACTIVE ☐

ANTIRETROVIRAL HISTORY OR CURRENT THERAPY OF _____

_____

LATEST CD4 COUNT: _____ LATEST VIRAL LOAD COUNT: _____

GUARDIAN DETAILS

GUARDIAN FIRST NAME: _____ GUARDIAN SURNAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: ☐☐ ☐☐ ☐☐

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

MEDICAL AID DETAILS

Strictly confidential

MEDICAL AID: _____ MEDICAL AID NUMBER: _____

PLAN OPTION: _____ DEPENDENT CODE: _____

DOCTOR'S DETAILS

PROOF OF IDENTIFICATION MUST BE SIGNED BY EXAMINER

I, THE EXAMINER acknowledge that I have counselled the applicant on the usage of the medication. 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 MEMBER

For registration the child will be required to undergo a physical examination and have blood tests taken every 16-20 weeks and only on request of the case manager. If there are any queries please do not hesitate to ask your doctor doing this examination about any of these tests.

I, THE MEMBER acknowledge that the examiner has explained the usage of the medication. I, THE MEMBER acknowledge that my child is HIV positive and consent to the use of the appropriate HIV/AIDS medication prescribed by the treating service provider. I the member acknowledge that I will be responsible for any co-payment that may be imposed as pe scheme rules.

I _____ the member / guardian 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 the child's HIV infection may be used for purposes of scientific, epidemiological and/or financial analysis without disclosure of names 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 ☐

* DOCTOR'S ROOMS OR POST OFFICE : _____

_____

_____

CODE: _____

continue overleaf

MEDICAL HISTORY

Strictly confidential

*** ICD 10 CODE:** _____ * DATE FIRST HIV POSITIVE: _____

HAS THE PATIENT EVER HAD ONE OR MORE AIDS DEFINING ILLNESSES? YES ☐ NO ☐

* DOES THE PATIENT HAVE ANY DRUG ALLERGIES? _____

* PLEASE LIST ANY OTHER ILLNESSES OR CHRONIC CONDITIONS? _____

* PLEASE LIST CHRONIC TREATMENT: _____

*** HEIGHT cm:** _____ *** WEIGHT kg:** _____

TREATMENT DETAILS

*** PREVIOUS AND OR CURRENT HIV TREATMENT**

MEDICATION	FROM DATE	TO DATE

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

_____

_____

SEROLOGICAL TESTS

URINE DIPSTICK: _____ TB SCREENING TEST PERFORMED YES ☐ NO ☐

RESULT POSITIVE ☐ NEGATIVE ☐

TB MEDICATION _____

_____

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

Please attach an original script for all ARV and prophylactic medication.

MEMBER / GUARDIAN ID NUMBER : _____ CHILD'S ID NUMBER : _____

PLACE: _____

MEMBER / GUARDIAN SIGNATURE : _____ DATE: _____