

**PATIENT APPLICATION FORM - CONFIDENTIAL
(TO BE COMPLETED BY THE PATIENT)**

MEDICAL AID DETAILS

Medical Scheme _____

Membership number

Gender

Benefit option _____

PRINCIPAL MEMBER DETAILS

Surname _____

First Name(s) _____

ID Number

Gender

PATIENT DETAILS

Surname _____

First Name(s) _____

ID Number

Gender

Dependant Code

Date of Birth

CONTACT DETAILS

Tel (h) _____ Tel (w) _____

Cell _____ E-mail _____

ALTERNATIVE CONTACT DETAILS

First Names _____ Surname _____

Tel(h) _____ E-mail _____

Cell _____

PREFERRED DELIVERY DETAILS

Home Work Doctor's room Postal

Address _____

Postal code _____

DISCLAIMER

Patient confidentiality

All member/patient information disclosed by means of this application will be treated as confidential and will not be revealed in any form to any other party other than the member's referring/treating doctor, medical scheme or administrator, unless written consent has been given to One Health/Optipharm by the patient. The patient herewith authorises the referring doctor/centre and current and future pathology service providers to disclose test results and examination findings to Optipharm/One Health.

Prescription

A prescription of your current medication must be faxed to Optipharm or any other means convenient to you. Optipharm will not accept responsibility for any side effects or conditions arising from taking the prescribed medication or from not following the instructions as supplied by the treating doctor and pharmacist.

Responsibility

The applicant acknowledges that his/her treating doctor retains responsibility for the patient's treatment and diagnosis. The applicant agrees to undergo medical examinations and the required blood tests such as CD4, Viral Load and FBC every four to six months on request by their Case Manager. The applicant understands the importance of taking his/her medication correctly and the importance of programme adherence. The applicant further understands and acknowledges that failure to remain adherent to their treatment may lead to the cancellation of benefits from their Scheme for the condition and their termination from the programme.

The applicant acknowledges that he/she is ultimately responsible for payment of services to the provider and as such undertake to pay Optipharm/One Health any such monies due for services supplied, levies, co-payments or rejections and to inform Optipharm/One Health of any changes pertaining to their medical scheme. The applicant acknowledges that providing correct and authenticated delivery details remains that of the applicant. Optipharm/One Health cannot be held liable for any breach of confidentiality perpetrated by the applicant or any third party service providers.

Applicant signature

Date

PATIENT APPLICATION FORM - CONFIDENTIAL (TO BE COMPLETED BY THE TREATING DOCTOR)

CLINICAL HISTORY

Date of first HIV diagnostic test

Reports

Date of Incident

PEP

Treatment start date

TB

EDD

Pregnancy

Has the patient been on a previous ARV Regime?

Date	Medication	Duration (months)	Reason for discontinuation

Does the patient have allergies to any of the following?

Sulphonamides

Aspirin

Penicillin

Other _____

Other medication used on chronic or regular basis

Date	Diagnosis	Medication	Duration

HOSPITALISATION RECORDS FOR THE LAST 12 MONTHS

Date	Diagnosis

SOCIAL HISTORY

Heavy alcohol intake

Smoking

Recreational drug use

CLINICAL EXAMINATION

Height	<input type="text"/>	BMI	<input type="text"/>
Weight	<input type="text"/>	BSA	<input type="text"/>
WHO Staging	<input type="text"/>	CDC Classification	<input type="text"/>

Other significant findings _____

Does the patient need counselling? Yes No

SPECIAL INVESTIGATIONS

	Date performed	Report Y/N
CD4 count		
CD4%		
CD8		
FBC		
Viral Load		

DOCTOR'S DETAILS

Name _____

BHF Practice number _____

HPC Reg number _____

Practice postal address _____

_____ Postal code _____

Physical address _____

_____ Postal code _____

Telephone number _____ Fax number _____

SCRIPT

NAME, STRENGTH & DOSAGE OF MEDICATION CURRENTLY PRESCRIBED	MONTHLY QUANTITY	REPEATS

Doctor's signature

Date

IMPORTANT INFORMATION

Customer Care call centre: 0860 906 090
Fax number: 086 500 9822
Telephone number: 011 251 9400
Emergency number: 083 564 9978
e-mail: bestmed@optipharm.co.za
Website: www.optipharm.co.za