prime cure health
leading integrated healthcare

CDL Chronic Application Form

IMPORTANT NOTE: *To be completed by General Practitioner. Only complete this form for CHRONIC medication for any CDL condition(s) (see section E). Attach the prescription and supporting documentation (labratory results or motivation), if necessary, to the application. Fax the documents to 0866 764 374 or email pcauth@mediscor.co.za.*

A Dispensing Provider

Indicate by Means of a Cross (x)

- ◯ Dispensing GP
- ◯ Network Pharmacy
- ◯ Medipost (Courier Pharmacy) Practice Number: 6065732

B Doctor Details

Referring Doctor: | Practice No:
Tel (W): | Tel (C):
Fax: | Email:

C Principal Member Details

Surname: | Initials:
Medical Aid: | Option:
Medical Aid No: | Employer:

D Patient Details

Title: | Gender: ◯ Male ◯ Female | First Name:
Surname: | ID No:
Dependant Code: | Tel (H):
Tel (W): | Tel (C):
Email:
Postal Address: | Code:

E CDL Chronic Conditions

Indicate by Means of a Cross (x)

◯ Addison's Disease	◯ Chronic Obstructive Pulmonary Disease (COPD)	◯ Diabetes Mellitus Type I	◯ Hyperlipidaemia	◯ Scizophrenia
◯ Asthma		◯ Diabetes Mellitus Type II	◯ Hypertension	◯ Systemic Lupus Erymatosus
◯ Bipolar Mood Disorder	◯ Chronic Renal Disease	◯ Dysrhythmias	◯ Hypothyroidism	◯ Ulcerative Colitus
◯ Bronchiectasis	◯ Coronary Artery Disease	◯ Epilepsy	◯ Multiple Sclerosis (MS)	◯ Chronic Depression
◯ Cardiac Failure	◯ Crohn's Disease	◯ Glaucoma	◯ Parkinson's Disease	◯ Gout
◯ Cardiomyopathy	◯ Diabetes Insipidus	◯ Haemophilia	◯ Rheumatoid Arthritis	◯ HRT

◯ Other _____

F Patient's Medical Information

Include copies of results or reports, both diagnosing and latest where necessary, to prevent delays in the review of this application

Weight: KG | Height: CM | BMI: | Smoker: Yes No | Cigarettes per day:
Waist Circumference: CM | Allegies:
Blood Pressure Reading: | Date Taken: DD MM YYYY
Blood Glucose: | Date Taken: DD MM YYYY
Random: | Fasting:
GTT: | HbA1c:

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Lipogram:		**Date Taken:**	D D M M Y Y Y Y
Total Cholestrol:		HDL:	
LDL:		Triglyceride:	
Creatinine Clearance:		**Date Taken:**	D D M M Y Y Y Y
Microalbuminuria:		**Date Taken:**	D D M M Y Y Y Y
Lung Function:		**Date Taken:**	D D M M Y Y Y Y
FEV1:		FEV / FVC:	

Indicate if the patient has a history of the following:

- ◯ Ischaemic Heart Disease / MI **Date:** D D M M Y Y Y Y
- ◯ TIA / Stroke **Date:** D D M M Y Y Y Y
- ◯ Arteriosclerosis **Date:** D D M M Y Y Y Y
- ◯ Peripheral Vascular Disease **Date:** D D M M Y Y Y Y

First degree relative with premature heart disease:

- ◯ Female < 65 Years
- ◯ Male < 55 Years

G Chronic Medication Application

Prescribe according to the Prime Cure medicine formulary and chronic disease list. Only Medication on the formulary will be covered. The formulary is available for lookup on www.primecure.co.za.

Chronic Condition (e.g. Hypertension)	**ICD 10 Code** (e.g. J10)	**Date of Initial Diagnosis** (e.g. 07/01/2018)	**Medicine Name, Strength & Dosage**	**No of Repeats** (If Not Ongoing)	**How Long Has The Patient Used This Medicine**	
					Months	Years
		D D M M Y Y Y Y				
		D D M M Y Y Y Y				
		D D M M Y Y Y Y				
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		D D M M Y Y Y Y				

H Clinical Motivation / Additional Comments

Doctor Signature: _____ Application Date: D D M M Y Y Y Y

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