All the quality care you need.

FORMULARY
CDL Chronic Conditions

TO BE COMPLETED BY GENERAL PRACTITIONER

INSTRUCTIONS

1. Please only complete this form for CHRONIC medication (ON & OFF-FORMULARY).
2. Please clearly indicate who dispenses the medication (pharmacy or dispensing practitioner)
3. Attach prescription
4. Fax application and prescription to 0866 764 374

PLEASE INDICATE (mark with an X)

PHARMACROSS ☐

GP or RETAIL PHARMACY ☐

MEDIPOST ☐

Designated Service Provider Details

Treating Doctor ______ Practice Stamp

Practice number ______

Tel ______

Cell ______

Fax ______ Pharmacy Name ______

Address ______

______ Code ______

Patient Details

Gender ☐ Male ☐ Female — Age ______

First name ______ — Medical Scheme name ______

Surname ______ — Medical Scheme Option ______

Identity Number ______ — Membership Number ______

Contact Tel ______ ______ — Dependant Code ______

Cell ______ ______

Other Contact Number ______ ______

Address ______

______ Code ______

E-mail ______

Additional Mandatory Information (where applicable)

Weight (kg) ______

Height (cm ______

BMI ______

Smoker ☐ Yes ☐ No

Please make sure the following information is included for HYPERLIPIDAEMIA

Lipid Profile Form ☐

Fasting Lipogram ☐

Cigarettes per day ______

Family History

Obesity ☐

Metabolic Syndrome ☐

Hypertension ☐

Diabetes Mellitus Type I ☐

Diabetes Mellitus Type II ☐

Asthma ☐

Fam Dyslipidaemia ☐ — Total Cholesterol > 7 ☐

CVI ☐ — Age developed: Mother ☐ < 64 years ☐ > 65 years; Father ☐ < 54 years ☐ > 55 years

IHD / MI / Angina ☐ — Age developed: Mother ☐ < 64 years ☐ > 65 years; Father ☐ < 54 years ☐ > 55 years

Other ☐ Specify ______

You're in safe hands

CDL Chronic Conditions

Condition		Condition	
Addison's Disease	☐	Haemophilia	☐
Asthma	☐	Hyperlipidaemia	☐
Bipolar Mood Disorder	☐	Hypertention	☐
Bronchiectasis	☐	Hypothyroidism	☐
Cardiac Failure	☐	Multiple Sclerosis	☐
Cardiomyopathy	☐	Parkinson's Disease	☐
Chronic Renal Disease	☐	Rheumatoid Arthritis	☐
COPD	☐	Schizophrenia	☐
Coronary Artery Disease	☐	Systemic Lupus Erymatosus	☐
Chrohn's Disease	☐	Ulcerative Colitis	☐
Diabetes Insipidus	☐	Epilepsy	☐
Diabetes Mellitus Type I	☐	Other, i.e. Depression, Gout, HRT, etc	
Diabetes Mellitus Type 2	☐	Please give details of disease &	
Dysrhythmias	☐	ICD10 code	
Glaucoma	☐		

INFORMATION ON HOW TO COMPLETE THIS FORM

1. Chronic authorisation is subject to the list of Chronic illnesses as included in the scheme rules.
2. Decisions are taken on presented in formation and are contingent on available clinical and diagnostic test results or examionations.
3. A motivation with new clinical information can change the original decision and should be handed in with a chronic application form.

Clinical Motivation (if required)

Prescription (please write prescription here, or attach to fax)

Patient Name

Surname

Rx

1

2

3

4

5

6

Attending Doctor ______________ Signature ______________ Date Y Y Y Y M M D D