prime cure health
leading integrated healthcare

Specialist Referral Form

IMPORTANT NOTE: *To be completed by General Practitioner. Any Procedure not listed requires pre-authorisation: Prime Cure: 0861 665 665 or Email: auth@primecure.co.za or Fax: 0865 207 980. Pre-authorisation number should be recorded on the account to be considered for payment. Please submit your account electronically using the following destination code - 642P, alternatively post claims to: Private Bag X13, Rivonia, 2128*

A Doctor Details

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

B Principal Member Details

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

C Patient Details

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

E Reasons for Referral

Clinical / Professional Diagnosis: ____________________________

Motivation for Referral: ____________________________

Date of Onset: D D M M Y Y Y Y ICD 10 Code:

F Specialist Practioner's Details

Specialist Name: Consult Date: D D M M Y Y Y Y
PR No: MP No:
Tel (W): Tel (C):
Fax: Email:
Authorisation No: Auth Date: D D M M Y Y Y Y

F Concomittant Medication - Patient Current Medication

Diagnosis (e.g. Hypertension)	ICD 10 Code (e.g. J10)	Medication Description (e.g. HZTZ)	Strength (e.g. 25mg)	Directions (e.g. 1/Daily)	Date of Diagnosis (e.g. Month & Year)	Repeats (e.g. 6/12)	Dispense (Self / Medipost)
					M M Y Y Y Y		
					M M Y Y Y Y		
					M M Y Y Y Y		
					M M Y Y Y Y		

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G Special Investigations

Date (e.g. 07/01/2018)	Test Description (e.g. FBC)	Result
DDMMYYYY		
DDMMYYYY		
DDMMYYYY		
DDMMYYYY		

H Additional Information

Complete if relevant to diagnosis

Weight: ____ KG Height: ____ CM BMI: ____ Smoker: Yes No Cigarettes per day: ____

Is this referral related to:

- Injury on Duty Date: DDMMYYYY
- Previous Motor Accident Date: DDMMYYYY

General Practitioner Signature: ______________________________| Application Date: DDMMYYYY