



WELLNESS FORM

INSTRUCTIONS:

Contact no: 086 010 3454

The patient and doctor section must be completed in full. We will not process incomplete applications.

Email completed application forms to: wellcare@sizwehosmed.co.za

TO BE COMPLETED BY APPLICANT

MEMBERSHIP DETAILS

Scheme:					
Option:					
Membership number:					
Surname:		Title:		Initials:	
Email:					

PATIENTS DETAILS

Surname:		Title:		Initials:									
(as per ID) First Name (s):													
Date of birth:	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	ID Number:			
D	D	M	M	Y	Y	Y	Y						
Membership number													
Physical address:													
			Code										
Tel (work):													
Tel (home):													
Email:													

If the account holder is not the principal member of the Scheme, the principal member agrees to refund monies being paid into the above account and both Sizwe Hosmed Medical Scheme and its administrator, 3Sixty Health, are not responsible for this money once paid. I hereby declare that the information on this form is true and correct and that any false information will render my EFT application null or void.

Patient's signature _____
(not required if minor)

Date:

D	D	M	M	Y	Y	Y	Y
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WELLNESS FORM

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DOCTOR DETAILS

Surname:		Title:		Initials:	
Physical address:					
		Code:			
Tel (work):					
Tel (home):					
Email:					
Doctor's Practice Number:					
Speciality:					

Clinical history

Male/Female:	M	☐	F	☐	Weight:		,	Height cm:		Blood pressure:		/	
Allergies:	Penicillin	☐	Asprin	☐	Sulphonamides	☐	Other	☐					

1. Date seropositive (HIV+) status confirmed:

D	D	M	M	Y	Y	Y	Y
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2. Has the patient had one or more aids defining illnesses:

Yes ☐ No ☐

Specify:

3. Incidents of TB or Pneumonia in past 5 years:

Yes ☐ No ☐

4. Incidents of diarrhoea >4 weeks in the last 6 months:

Yes ☐ No ☐

5. Any significant Lymphadenopathy:

Yes ☐ No ☐

6. Candidiasis:

Yes ☐ No ☐

7. Any abnormal dermatological findings:

Yes ☐ No ☐

Specify:

8. Other chronic conditions:

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9. Weight loss in the past year:

	kg		N/A
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10. No. Of hospital admissions:

	Year		3 Years
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WELLNESS FORM

11. SEROLOGICAL TESTS (Please attach laboratory results)

Urine dipstick

Delivery date:

D	D	M	M	Y	Y	Y	Y
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Is the member pregnant:

Yes ☐

No ☐

N/A ☐

EED

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C Section

Fax copies of blood results:

Date		
Hb		
wee		
Platelets		
Neutrophils		
ALT		
Cd4 count		
Cd4%		
Viral load		
Viral logs		

12. PREVIOUS ANTI-RETROVIRAL TREATMENT

Medication	Duration of treatment	Reason(s) for discontinuation ()
		Cost ()
		Side effects ()
		Non-response ()
		Other ()

13. MEDICATION PRESCRIBED (Please fax copy of prescription)

Detailed diagnosis and date of diagnosis	Name (trade name or generic equivalent)	Strength (e.g. 50mg)	Directions (e.g. 2tds)	Date medication started	Type and date of investigation/report (Please attach copy)

I, the examining doctor, certify that the particulars hereto are to the best of my knowledge, true and accurate, having conducted a personal examination; procured the diagnostic tests and investigations referred to; counselled the applicant on the usage of anti-retroviral therapy and the consequences of non-compliance.

Members can use any Pharmacy of their choice. However Preferred Providers will provide excellent service and dispensing fee rates making your medicine benefits last longer.

Patient's name: _____

Nature of examining doctor: _____

Date:

D	D	M	M	Y	Y	Y	Y
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