SIZWE HOSMED
MEDICAL SCHEME
*Your choice for quality care*

086 010 3454
wellcare@sizwehosmed.co.za
23 West Street,
Houghton Estate,
Johannesburg,
2198

# 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: | D D M M Y Y Y Y | ID Number: | | | |
| 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
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:
9. Weight loss in the past year: ☐ kg ☐ N/A
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

Is the member pregnant: Yes ☐ No ☐ N/A ☐ EED ____ 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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