Medimed
Managing your healthcare security

DISEASE MANAGEMENT APPLICATION

A. IMPORTANT INFORMATION

1. You need to complete this application form to enrol on the Scheme's Disease Management Programme
2. An application must be completed per beneficiary applying for enrolment
3. You will receive an SMS confirming your enrolment on the programme
4. Send forms via fax 0865994511, mail PO Box 1672, Port Elizabeth, 6000 or e-mail wellbeing@medimed.co.za

B. BENEFICIARY DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID No

Telephone number (Home) | (Work)

Fax number (Confidential) | Cellular

Email address (Confidential)

Postal Address

Code

C. HEALTH INFORMATION

Medical History

Family History: Y N If yes, supply details

Recent Hospital admissions Y N

Have you ever utilised or been referred to the following services: (Please tick) Dietician | Podiatrist

Opthalmologist | Specialist Physician | Healthy Start Program | Psychologist/Counsellor

Health Indicators:

Weight (kg) | Height (m) | Hip/Waist ratio | Alcohol use Y N | Ave/day

Smoker Y N | Ave/day | How long have you smoked | When did you stop

Exercise: Frequency (X per week) | Intensity: Low | Medium | High | Min/day

Heart Rate: | Allergies? Y N If yes, supply details

Surname | Initials | Membership Number

D. SCREENING TESTS

Mammogram | Pap Smear | PSA | ECG | HIV test

Blood pressure (mmhg) | Blood Glucose (mmol/l) | Cholesterol

Please include results if available, it is important to **Know YOUR Numbers**

E. TREATMENT DETAILS

Please provide the details for your chronic condition/s. Chronic medication authorisation **I H C**

Description of Condition	Date of Diagnosis	Treatment	Doctor

Please include copies of the most recent relevant pathology and diagnostic tests

F. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the Disease Management & Wellbeing Team;
- Any information concerning this application will remain confidential at all times;
- My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's) condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns.
- Momentum TYB shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of

Client Signature _____ Date Y Y Y Y M M D D

(or member if patient is a minor)