STRICTLY CONFIDENTIAL

LifeSense Disease Management
PAEDIATRIC APPLICATION:
Bestmed Medical Scheme
Members

Please complete this form and return it to LifeSense.
Email: results@lifesense.co.za
Fax: 0860 80 49 60

Please note: All fields marked with * are compulsory fields: If not completed your application will not be processed.

MAIN MEMBER DETAILS	
Surname	
Name(s)	
ID Number	
Gender (Male / Female)	

CHILD'S MEDICAL AID DETAILS					
Medical Scheme			Medical Scheme Number		
Scheme Option			Dependant Code		
CHILD'S DETAILS					
Surname					
Name(s)					
ID Number		Male		Female	
Date of Birth	DD/MM/YYYY				
Birth Delivery Method	Natural Delivery Caesarean Section:				
MOTHER'S DETAILS					
Name			Surname		
HIV Status Mother	Reactive:		Non-Reactive		
Mother Latest CD4 Count	Date: Result:		Mother Latest Viral Load Count		Date: Result:
GUARDIAN'S DETAILS					
Name			Surname		
Relationship			Date of Birth		
Physical Address					
Postal Code					
Province					
Postal Address					
Postal Code					
Province					
Telephone Number (H)	Include Dialing Code		Telephone Number (W)	Include Dialing Code	
Cell phone Number			SMS Number		
Preferred Follow Up	SMS E-Mail		E-mail Address		

NEXT OF KIN DETAILS		
Name & Surname:		
Relationship:		
Contact Number:		
Next of kin aware of Status	YES	NO

*__PHARMACY SELECTION__ based on choice please complete table 1 or 2 below Please select from the table below the Pharmacy of your choice from whom you wish to receive your medicine.			
Clicks Direct Medicine Courier Pharmacy		Clicks Retail Pharmacies	
Dis-Chem Direct (Previously Optipharm Courier Pharmacy)		Dis-Chem Retail Pharmacies	
Medipost Courier Pharmacy			

1: **RETAIL PHARMACY DETAILS** Required if your choice is a Retail Pharmacy: You will be responsible for collection of medicine	
Clicks Retail Pharmacies	Name of Clicks (e.g. Clicks East Rand Mall) Province Postal Code
Dis-Chem Retail Pharmacies	Name of Dis-Chem (e.g. Dis-Chem East Rand Mall) Province Postal

2: **MEDICINE DELIVERY ADDRESS** Required for Courier Pharmacy purposes: Courier pharmacy will deliver to the address as per below								
Please tick your preferred	Doctor		Home		Work		Post Office	
Delivery address								
Postal Code		Province						

MEDICAL INFORMATION: THIS SECTION HAS TO BE COMPLETED BY THE TREATING DOCTOR. ALL FIELDS MARKED WITH AN * HAVE TO BE COMPLETED. IF NOT COMPLETED, THE APPLICATION WILL NOT BE PROCESSED.

*ICD-10 Code		*Date First HIV Positive Test	
*Height		*Weight	
*Has the patient had / have any AIDS defining illnesses?	If YES: Please state below:		
*Medicine Allergies	If YES: Please state below:		
*Other Chronic Illnesses	If YES: Please state below: Chronic Illness medicines: Please state below:		

***TREATMENT DETAILS**	
*Previous treatment	If YES: Please state which drugs, please include Start and End Date:
*Current treatment	Please include start date of treatment:
*If Patient is Treatment Naïve, please list suggested treatment	
*Generic equivalent	Yes No
*PLEASE ATTACH ORIGINAL SCRIPT FOR ALL ART AND PROPHYLACTIC MEDICINES Should the applicant refuse a generic equivalent, then he/she may be liable for a co-payment as per the Scheme's rules	

BLOOD TESTS			
Date		Laboratory	
Requisition No.			
SEROLOGY TEST	**RESULT**	**SEROLOGY TEST**	**RESULT**
CD4 COUNT		VIRAL LOAD	
FBC		CREATININE	
PLATELETS		UREA	
ALT		AST	
PLEASE NOTE: 1. ONLY THE ABOVE TESTS ARE COVERED UNDER THE B24 CHRONIC BENEFIT 2. GENOTYPING REQUIRES PRIOR AUTHORISATION			
TB STATUS			
TB Screening	Yes No	Positive	Negative
TB Medicine			

DOCTORS DETAILS

PROOF OF IDENTIFICATION MUST BE SIGNED BY THE EXAMINER

I, **the Examiner** acknowledge that I have counselled the applicant on the usage of the medicine and should the applicant default in taking the medicine, it could lead to multi-drug resistant virus. Should the applicant refuse a generic equivalent, then he/she may be liable for a co-payment as per the Scheme's rules. I declare that I have taken due and proper care to verify the true identity of the applicant as stated above and have witnessed his/her signature.

DOCTORS PRACTICE DETAILS			
Surname		Name (Initials)	
Practice number		MP Number	
Practice address			
Postal code		Province	
Tel.		Fax	
Cell		E-mail	
Preferred means of communication	Fax E-mail	Are you willing to accept medicine deliveries to your rooms?	Yes No

Doctor signature	_____	Date	_____/_____/_____

***This section must be read and understood by the signed Applicant/Guardian**

Your child's participation in this programme is one of the most important ways to keep you well. For registration you will be required to answer medical questions, the child will have to undergo a physical examination and have blood tests taken every 24 weeks and only on request of the case manager. If you have any queries, please do not hesitate to ask your doctor doing this examination about any of these tests.

I, **the Applicant/Guardian** acknowledge that the examiner has explained the usage of the medicine to me, if applicable.

I, **the Applicant/Guardian** acknowledge that my child is HIV positive and consent to the use of the appropriate HIV/AIDS medicine prescribed by the treating service provider, if applicable. I the **Applicant/Guardian** acknowledge that I will be responsible for any co-payment that may be imposed as per medical scheme rules.

I, **the Applicant/Guardian** understand that in order for the payment of services to the doctor or any other service provider, the medical scheme will need to know my child's identity. I hereby consent to the above procedures. I agree that the medical information relevant to my child's HIV infection may be used for purposes of scientific, epidemiological and/or financial analysis without disclosure of my name and that LifeSense may send medical information to the treating doctor and medical scheme if required.

LifeSense and your medical scheme adhere to the confidentiality as laid out by the Health Professional Council of South Africa (HPCSA). All personal information collected will be stored in accordance with Protection of Personal Information (POPI) ACT.

I, **the Applicant/Guardian** also acknowledge receipt of the Bestmed Introduction letter and understand the contents therein.

Applicant/Guardian ID number		Child's ID number	
Applicant / Guardian signature	_____	Date	_____/_____/_____
Place			