Universal Healthcare Provider Network, a division of Universal Care
Universal House, 15 Tambach Road, Sunninghill Park, Sandton 2191
P O Box 1411, Rivonia 2128
Tel: +27 11 208 1100 / 0860 111 900 / Fax: 0862 108 743
Email: chronicmedicine@universal.co.za / www.universal.co.za

UNIVERSAL CHRONIC MEDICINE APPLICATION FORM

Completing the chronic medicine application form: Please print using block letters
1. Member/Employee to complete section 2 and patient consent and signature section 6
2. Treating doctor to complete section1,3 4,5 and doctor declaration and signature section 6
3. Once completed please email the completed application form to: Chronicmedicine@universal.co.za

1. PROVIDER DETAILS

Practice name: Practice number:

Office Tel: ( ) Email:

Physical address:

Postal code:

Postal address:

Postal code:

2. PATIENT DETAILS

Surname: First name/s:

Date of birth: D D M M Y Y Y Y Gender: M F Age:

Telephone no.: (H): ( ) (W): ( )

Cellphone number: E-mail address:

Physical address:

Postal code:

Postal address:

Postal code:

Occupation: Type of employment:

How would you prefer the outcome of the application status to be communicated to you? E-mail: Telephonically:

3. MEDICAL SCHEME DETAILS/OCCUPATIONAL HEALTH PRODUCTS

Medical Scheme: Medical Scheme Option: Workplace Health Plan:

Member/Policy /ID number: Dependent code:

4. PATIENT'S MEDICAL INFORMATION. (PLEASE PROVIDE INFORMATION RELEVANT TO PATIENT'S CHRONIC CONDITION/S)

Height (cm): Weight (kg): Waist circumference (cm): Date: D D M M Y Y Y Y

BMI: Blood pressure:

***Blood glucose:**

Random: Fasting: GTT: *HbA1c: Date: D D M M Y Y Y Y

***Lipogram:**

Total cholesterol: HDL: LDL Triglyceride:

*CD4 Cell Count: *Viral Load:

Microalbuminuria: *Creatinine clearance: Date: D D M M Y Y Y Y

Lung function:

*FEVI: *FEV/FVC:

Ejection Fraction: Hysterectomy: (Y) (N) Pregnant: (Y) (N)

Expected Delivery Date: D D M M Y Y Y Y

Allergies:

Please indicate if the patient has a history of the following:

Ischaemic heart disease/MI: Familial hyperlipidaemia:

TIA/Stroke: Peripheral vascular disease:

First degree relative with premature heart disease (Female < 65 years/ Male <55 Years)

Has patient been investigated for TB: (Y) (N) Has patient been treated for TB: (Y) (N)

5. CHRONIC MEDICINE APPLICATION (BLOCK LETTERS)

Registration of chronic condition only New application and/or new medicine Change in treatment

Please prescribe according to the formulary. Chronic condition list and Formulary available for lookup on www.universal.co.za

Diagnosis / Chronic Conditions/ ICD10 code	Medicine name and strength	Dosage	Number of repeats if different from ongoing

6. PATIENT AND DOCTOR CONSENT

Patient

- I understand that my personal and clinical information will be kept confidential.
- I give permission for my doctor to state the diagnosis of my condition.
- I confirm that the information contained in the application is correct.

Patient's signature

D D M M Y Y Y Y

Date

Doctor

- I have verified this application against the scheme chronic formulary and the chronic condition list.
- I hereby declare that the information provided is true and correct.

Doctor signature

D D M M Y Y Y Y

Date