Call Centre: 0860 102 182 Fax: 021 673 1815 Email: chronic.carecross@momentum.co.za

carecross

First name Title Medical scheme Surname Memborship number Option Section 2: Patient's details First name Dependent Code Date of birth Date of birth Despendent Code Despenden	Chronic Bene	fit applic	ation										
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Blood pressure Bypass Surgery Yes No Previous Myocardial Infarction TIA Yes No Other major disease Yes No Please provide details Environmental allergies 1. 2. Script details New Application Update Treatment Change Diagnosis (e.g. Hypertension) (e.g. 170) ICD10 Code (e.g. 170) Medication description (e.g. 25mg) (e.g. 170aily) "CareCross requires a copy of the first and latest Lipogram, and Risk Evaluation form, where applicable, to prevent a delay in the assessment of the application. Section 4: Doctor's details Surname Initials Qualifying degree Practice number Telephone Fax Section 5: Pharmacy preference			Yes	No		Т	reatment	On		Off			
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	Practice address												
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Patient's details									
Name		Medical aid number							
Telephone number			Date of birth D D M M Y Y Y Y						
Section 6: Declaration by General Practitioner									
I have verified this application against the Medicine List as well as the List of Exclusions in terms of the CareCross Benefit. I agree to generic substitution, where a cost									
effective, less expensive alternative exists. I her									
Signature of General Practitioner			Date D D M M Y Y Y Y						
Section 7: Declaration by me	mber								
I hereby authorise my doctor to furnish and/or d	isclose any fact relevant to this applic ssing of this application. I understand		s and medical results may be made available to CareCross Chronic Medicine Formulary as well as the						
Signature of member If minor, principal member must sign			Date D D M M Y Y Y Y						
Motivation for lipid-low	ering therapy								
Lipogram 1: Pre-treatment		Lipogram 2							
Date	D D M M Y Y Y	Date	D D M M Y Y Y Y						
Total cholesterol		On or off therapy							
LDL-cholesterol		Total cholesterol							
HDL-cholesterol		LDL-cholesterol							
Lipoprotein		HDL-cholesterol							
АроВ		Lipoprotein							
Triglycerides		АроВ							
		Triglycerides							
Clinical information Does the patient have evidence of ather schaemic heart (e.g. angina, myocardial in		y bypass craft)							
Cerebrovascular disease (e.g. transient iso	chaemic attack, stroke carotid bru	uits)*							
		,							
Peripheral vascular disease (e.g. intermitter	it claudication, absent periprierar	puises)							
Other (please specify)*									
Please provide full details									
Does the patient have other cardivascul	ar risk factors?								
Smoker (indicate no. of cigarettes per day)		Diabetes me	ellitus						
Obesity (weight kg height	m BMI	kg/m²)							
Hypertension Yes No	(Blood pressure	/ on or off the	herapy						
please specify)	illist-degree relative belore age s	oo (tot ilist-degree male rea	atives) and 65 (for first degree female relatives)						
Does the patient have clinical features o	of hyperlipidaemia?								
-	helasma	Arcus cornealis							
Has the patient had any of the following									
TSH Urine dips	tix	andom blood glucose /gluco	ose tolerance test						
Liver function tests	Serum urea/creatinine								
Has any lifestyle modification been attemp	led?	yes, for how long?							