UMVUZO HEALTH

rx health

www.umvuzohealth.co.za

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SPINAL PROGRAMME QUESTIONNAIRE

Sections A and B must be completed by the patient. For minor children, the responsible adult needs to complete and sign.
Please submit the completed form along with supporting documentation to email: auth@rxhealth.co.za

A. PATIENT DETAILS (ALL FIELDS ARE MANDATORY)

Patient name and surname			
Membership number		Patient date of birth	Y Y Y Y M M D D
Patient age		Weight	
Height			
Employer group		Current occupation	
Duration in this occupation		Contact number	

B. QUESTIONNAIRE

How and when did the problem start? (e.g., in a motor vehicle accident, injured on duty, or any other injury/trauma of the spine).

Motor vehicle accident		Injured on duty		Other injury/trauma of the spine	

Please provide the details - what happened and when did it happen?

Have you suffered from a previous spinal injury? Y N

If 'Yes', please indicate when, which hospital, which treating doctor and which part of the spine was operated on

Date of injury	Y Y Y Y M M D D	Hospital/medical facility	
Treating doctor/surgeon		Spinal injury location	
Date of operation	Y Y Y Y M M D D		

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Describe your symptoms: (Please select 'Yes' or 'No', or the option that relates to you).

Can you walk/climb stairs?	Y	N	How far can you walk?	None	<1km	1 - 5km	>5km

Do you have sensations of tingling, numbness or "pins and needles" in certain body parts?	Y	N

If 'Yes', please specify which body part(s)

If 'Yes', how often?	Every day	Once a week	Once in a while	Never

Do you frequently experience balance or coordination issues?	Y	N

In your own words, please explain your symptoms and how they started.

C. TESTS CONDUCTED

The treating healthcare practitioner must complete sections C, D, E and F on behalf of the patient. Please indicate if the patient has undergone any of the below and if the results are included.

Has the patient received spinal X-rays?				Y	N
Anterior/Posterior	Y	N	Results included	Y	N
Lateral	Y	N	Results included	Y	N
Flexion/extension of lower back (in the case of pain)	Y	N			

Please state any scans the patient has undergone, e.g. MRI.

Was an EMG Test performed?	Y	N	Results included	Y	N

D. CURRENT TREATMENT

Please specify all patient details.

Please list all current and chronic medications the patient is taking, with the latest available pathology results relevant to the chronic medicine.

Is the patient currently undergoing physiotherapy and/or biokinetics?

Physiotherapy	Y	N
Biokinetics	Y	N

If 'Yes', please provide a report.

E. ADDITIONAL INFORMATION

Please indicate 'Yes' or 'No'.

Does the patient experience spinal pain at night?	Y	N

If 'Yes', please specify details.

Does the patient have a history of cancer?	Y	N

If 'Yes', please specify details.

Has the patient experienced weight loss recently?	Y	N

If 'Yes', please specify details.

Is the patient feverish?	Y	N

If 'Yes', please specify details.

Does the patient have a history of TB? Y N

If 'Yes', please specify details.

Is the patient immunocompromised? Y N

If 'Yes', please specify details.

Does the patient smoke cigarettes? Y N

If 'Yes', please specify details.

F. TREATING HEALTHCARE PRACTITIONER DETAILS

To be completed by the treating healthcare practitioner.

Full name and surname	
Discipline	
PR number	
Contact number	
E-mail address	
Practice physical address	

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To be completed by Patient

G. DECLARATION

I, ____ (name and surname), with Umvuzo Health membership number ____________________ hereby confirm that all the information provided within this form is true and accurate.

I acknowledge and understand that spinal surgery in accordance with Rules 1.29 and 1.30 in Annexure C (Exclusions and Limitations) of Umvuzo Health's Scheme rules, are excluded from Scheme benefits unless certain clinical criteria are met.

I understand that Umvuzo Health Medical Scheme has an agreement with a Secondary Referral Centre to evaluate all clinical information as received from my treating specialist and that participation and/or benefits on the Spinal Programme is not guaranteed.

Signature

Date Y Y Y Y M M D D

Contact number