UMVUZO HEALTH

rx health
an UMVUZO HEALTH Partner

CHRONIC DISEASE MANAGEMENT PROGRAMME REGISTRATION

This registration form should be used for Umvuzo Health members registered for CDL PMB conditions.

1. Please complete one registration form per beneficiary to be registered.
2. Please complete the registration form in black pen for legibility.

General

1. For telephonic registration, questions, or support, please contact **Mediscor** on **086 011 3238**.
2. Email completed registration forms to: preauth@mediscor.co.za.

HEALTH CARE PROFESSIONAL'S DETAILS

Doctor		Practice number	
Contact details	Tel	Fax	
	Cell	Email	

PATIENT DETAILS

Gender	Male		Female	Age	
Surname					
First name					
Tel		Cell			
Identity number					
Medical scheme	Umvuzo Health	Option			
Member number		Dep code			

RISK INDICATORS

Condition ICD10		Year of diagnosis			
Regular exercise	Y N	Waist circumference	cm		
Weight	kg	Height	m	BMI	
Smoking	Y N	For how many years		Number per day	
Alcohol use	Y N	Social		Regular	

DIABETES MELLITUS

Amount of glucometer test strips needed per month			
HbA1c		Date of last HbA1c test	
Finger prick plasma glucose fasting range			
Finger prick plasma glucose 2 hours post-prandial range			

CURRENT MEDICATIONS (ALL)

_____

_____

_____

_____

Member number		Dep code	

BLOOD AND URINE PROFILE

Total cholesterol		LDL		HDL		TG	
Blood pressure			Urine microalbuminuria		Serum creatinine		
GFR							

OTHER CHRONIC DISEASES

DATE OF FOOT EXAMINATION AND RESULTS.

DATE OF EYE EXAMINATION FOR RETINO PATHOLOGY AND RESULTS.

STRESS ECG RESULTS

LEGAL DECLARATION

I the undersigned, (name and surname) _____
declare that I have received individual counselling and education on Chronic condition in a language that I understand, and that I am able to make an informed decision to register on the Chronic Disease Management Programme of Rx Health, the contracted managed health care organisation of Umvuzo Health.

I understand that Rx Health must access my personal information to make recommendations about my treatment needs and to provide me with the full benefits of the Disease Management Programme.

I authorise any third party, previous scheme or health care professionals, for example, pathology laboratories, doctors, pharmacies and hospitals, in possession of any medical information about me or my dependants (if minor) to provide it to Rx Health to assist in the provision of my care. I acknowledge that my health care professional will request for pathology tests for the ongoing monitoring, clinical management and treatment of my conditions.

I understand that the pharmacies and service providers are bound by the ethical and legal guidelines of health care professionals to protect my information.

Patient signature _____ Date Y Y Y Y M M D D

(legal guardian for a minor)

Treating Provider signature _____ Date Y Y Y Y M M D D

Practice Number _____

ADDRESS FOR DELIVERY OF MEDICINE

Address							
Telephone (home)			Telephone (work)				
Cell							
Indicate preferred contact method	Home		Work		Cell		
Convenient time of day	Any time		Morning		Afternoon		Evening	

Please notify us immediately if you change your contact details.

WHAT DO YOU RECOMMEND FOR YOUR PATIENT?

On disease specific education	Y	N
Client supplementation on disease specific diet	Y	N
Patient is ready for treatment	Y	N

Do you have any comments for Rx Health? _____