PROVIDENCE
Healthcare Risk Managers

## DISEASE MANAGEMENT APPLICATION FORM

## A. IMPORTANT INFORMATION

1. You need to complete this application form to enrol on the Scheme's Disease Management Programme

2. An application must be completed per beneficiary applying for enrolment

3. You will receive an SMS confirming your enrolment on the programme

4. Send forms via fax 041 395 4599, mail PO Box 1672, Port Elizabeth, 6000 or e-mail wellbeing@providence.co.za.

B. BENEFICIARY DETAILS																													
Scheme															Option														
Membership Number																													
Surname															First Names														
Title	Title         Date of Birth         Y         Y         Y         M         D         D         ID No																												
Telephone	Telephone number (Home)																												
Fax number (Confidential)   Cellular																													
Email address (Confidential)																													
Postal Ad																													
C. HEALTH INFORMATION																													
Medical History     Recent Hospital admissions     Y     N       Family History:     Y     N     If yes, supply details     If yes, supply details																													
Have you ever utilised or been referred to the following services:       (Please tick)       Dietician       Podiatrist         Opthalmologist       Specialist Physician       Healthy Start Program       Psychologist/Counsellor         Health Indicators:       Healthy Start Program       Psychologist/Counsellor																													
Interactions.         Weight       kg       Height       m       Hip/Waist ratio       Alcohol use       Y       N       Ave/day         Smoker       Y       N       Ave/day       How long have you smoked       When did you stop																													
Page 1 of 2 STES PO Box 1672, Port Elizabeth, 6000 Tel: +27 41 395 4400 Fax: +27 41 395 4597 WWW.providence.co.za																													

D. SCREENING TESTS			-									
Mammogram Pap Smear PSA ECG ECG	HIV te	HIV test										
Blood pressure mmhg Blood Glucose mmol/l Cholesterol												
Please include results if available, it is important to Know YOUR Numbers												
E. TREATMENT DETAILS												
Please provide the details for your chronic condition/s. Chronic medication authorisation												
Description of Condition Date of Diagnosis Treatment	t Doctor											
	-											
Please include copies of the most recent relevant pathology and diagnostic tests												
F. PATIENT DECLARATION												
By signing below, I hereby give permission for, acknowledge and/or agree to the following:												
<ul> <li>My (or my minor dependant's) doctor may provide clinical information regarding my/minor's condition to the PBM Team;</li> </ul>												
Any information concerning this application will remain confidential at all times;												
• My (or my minor dependant's) doctor retains the responsibility for my (or my minor dependant's)												
condition, based on the understanding that I (or my minor dependant) also has a responsibility towards my (or my minor dependant's) own health concerns.												
<ul> <li>PROVIDENCE shall not accept responsibility for any act, errors or omissions, loss, damage or consequences of individual responses to the treatment authorised or not authorised for funding by the Scheme.</li> </ul>												
Client Signature Date Y Y Y M M D D												
(or member if patient is a minor)												
Page 2 of 2       Administered by PROVIDENCE Healthcare Risk Managers (Pty) Ltd. Reg. No.1993/006699/07       Version 4 (February 2012         PO Box 1672, Port Elizabeth, 6000 Tel: +27 41 395 4400       Fax: +27 41 395 4597         www.providence.co.za       Www.providence.co.za												