Bomaid

The medical aid you can trust

Chronic Ailment Form

A. YOUR DETAILS OF COVER - Level of cover (Please tick one box only)

A Healthplan ◯ B Healthplan ◯ C Healthplan ◯ Student Healthplan ◯ A Standard Healthplan ◯ No co-payment ◯

B. PRINCIPAL MEMBER DETAILS - to be completed by the principal member

Name	
Surname	
Date of Birth	D D M M Y Y Y Y
Nationality	
Identity/ Passport No.	
Medical Aid Number	M
Male / Female (Please tick where appropriate)	M F
Postal Address	
Home Phone	
Work Phone	
Cell Phone	
Email 1	
Email 2	
Employer	

C. . PATIENT DETAILS - Please provide details of the patient who requires the medication

Dependent Code				ct Number	Sex
			D D M M Y Y		M F
			D D M M Y Y		M F
			D D M M Y Y		M F

I hereby give consent that this application for chronic medication be given to BOMAID to perform drug utilisation review (DUR) if this service is provided for the sole purpose of enhancing my medical benefit. I understand that BOMAID needs to access personal clinical information in order to make informed recommendations regarding my chronic medication. I therefore authorise any medical service provider in possession of any medical information regarding myself or any of my dependants to provide BOMAID sufficient information that they may require, excluding any information which i stipulate in writing to my medical service provider. I acknowledge that my medical service provider retains responsibility for my treatment and diagnosis.

I hereby certify that the information provided on this application form is correct and I understand the terms of this application. I also understand that my participation is subject to my eligibility under the Medical Society.

Generic medication can significantly reduce prescription costs, while proviiding similar medical effect. Should there be a equivalent available (after agreement with yourDoctor) would you be prepared to use generic product?

Yes ◯ No ◯

Signature Principal Member	Date

D. MEDICAL PRACTITIONER'S DETAILS - To be completed by the attending Medical Practitioner

Name	
Surname	
Postal Address	
Home Phone	Fax
Work Phone	
Speciality	
Botswana Practice Number	
Email 1	
Email 2	

E. CONDITION AND MEDICATION DETAILS - To be completed by the attending Medical Practitioner (1 form per patient)

Patient name

Name	
Surname	

Chronic Condition	ICD 10 Code	Medication prescribed (State strenght, dosage & quantity)	Allergies	How long has the member been on this medication		How many repeat prescriptions would you like your patient to receive (months)				
				Years	Months	3	6	9	12	>12 Other
1.										
2.										
3.										
4.										

F. CLINICAL INFORMATION - To be completed by the attending Medical Practitioner

General

Weight ____ Kg Height ____ cm

Blood Pressure ____ mm/Hg

Smoker Y ☐ N ☐ Ave per day ____

Stress Level Mild ☐ Moderate ☐ Severe ☐

Exercise Mild ☐ Moderate ☐ Severe ☐

Please specify type of exercise ____

Patient History		Description	Family History	
Y ☐	N ☐	Heart Disease	Y ☐	N ☐
Y ☐	N ☐	Previous Myocardial Infarction	Y ☐	N ☐
Y ☐	N ☐	Other Major Ailments	Y ☐	N ☐

Please specify other ailments ____

If generic equivalent exists for products prescribed, may suitable generics be used for this patient (Please indicate with an X)

Yes ○ No ○

Medical Practitioner's Signature

Date