LIFESENSE DIABETES MANAGEMENT - APPLICATION FORM

Please complete this form and return to: diabetes@lifesense.co.za or Fax to: 011-912-1276

NOTE: *that all information supplied in this from by you and your doctor will be treated as strictly confidential.*

TEL: 0861 000 122 FAX: 011-912-1276 E-MAIL: diabetes@lifesense.co.za

LDMP/APP_V2_2016 WEBSITE: www.lsdiabetes.co.za

MAIN MEMBER DETAILS

SURNAME:		NAME:	
GENDER:		ETHNICITY:	
DATE OF BIRTH:		ID NUMBER :	
MEDICAL AID:		MED. AID NUMBER	
PLAN OPTION:		DEPENDANT CODE:	
JOIN DATE:		LANGUAGE PREFERENCE:	

APPLICANT DETAILS (IF NOT MAIN MEMBER)

SURNAME:		NAME:	
GENDER:		ETHNICITY:	
DATE OF BIRTH:		ID NUMBER :	
LANGUAGE PREFERENCE:		DEPENDANT CODE:	

APPLICANT EMPLOYMENT DETAILS

NAME OF EMPLOYER:		STUDENT: Y/N RETIRED: Y/N
EMPLOYMENT TYPE:	SHIFT: Y/N FULL TIME: Y/N	PART TIME: Y/N
IF SHIFT WORKER	DAY SHIFT: NIGHT SHIFT:	

APPLICANT CONTACT DETAILS

PHYSICAL ADDRESS:		E-MAIL:	
TOWN:		HOME TEL. NO.	
PROVINCE:		WORK TEL. NO.	
PREFERRED FOLLOW UP REMINDER (PLEASE TICK): SMS: E-MAIL:		CELL. NUMBER:	
		SMS NUMBER:	

ALTERNATIVE CONTACT DETAILS

NAME & SURNAME:		AWARE OF YOUR DIABETES : YES NO	
RELATIONSHIP:			
CONTACT NUMBER:		E-MAIL:	

DOCTOR DETAILS

NAME & SURNAME:			
SPECIALITY:		PRACTICE NO. :	
TEL. NO.:		HPCSA NO. :	
E-MAIL:		FAX. NO. :	
CELL NO. :		PREFERRED COMMUNICATION:	FAX: E-MAIL:
PHYSICAL ADDRESS:			

A script for the authorized medication will be generated by the Chief Medical Officer and LifeSense will send the script to the designated courier pharmacy / pharmacy as appointed by the medical aid.

I, THE EXAMINER acknowledge that I have counselled the applicant on the usage of all appropriate medication and the importance of adherence to medication in order to achieve and maintain the desired targets for diabetes and/ or hypertension and / or hyperlipidaemia.

The applicant is aware that should they default in taking their medication, it can result in the development of complications. . The applicant will be subject to using clinically appropriate generic / low cost alternatives, as per the schemes rules. Should the applicant refuse this option, their medication will be subject to the necessary co-payment. I declare that I have taken due and proper care to the true identity of the applicant as stated above, and have witnessed his/her signature.

DOCTOR SIGNATURE: _____ DATE:_____

APPLICANTS MEDICAL HISTORY

TYPE OF DIABETES: ICD-10 CODE:	TYPE 1: TYPE 2 ORAL: TYPE 2 ORAL + INSULIN: GDM:	DURATION OF DIABETES:	
CO-MORBIDITIES : ICD-10 CODE(s)		DRUG ALLERGIES:	
OTHER ILLNESSES			
WEIGHT:		HEIGHT:	
WAIST CIRCUMFERENCE:		SMOKER:	NO: YES: No/day:
BLOOD PRESSURE:		EXERCISE: NO: YES: Frequency:	

PLEASE ATTACH ANY RECENT RELEVANT PATHOLOGY RESULTS

CURRENT MEDICATION (DIABETES, HYPERTENSION, DYSLIPIDAEMIA)

MEDICATION NAME	DOSE	DURATION OF TREATMENT
Please supply updated script with ICD-10 Codes:		

Your medical scheme has contracted LIFESENSE DIABETES MANAGEMENT PARTNERS as their diabetes managed care organization. As a member of the scheme it is compulsory for you to sign up for the diabetes management program in order to continue to receive your chronic benefits for diabetes as outlined by your scheme. Your doctor has completed the registration form with your consent, and once you are registered on the program you will receive a registration and confirmatory call from a LIFESENSE case manager. LifeSense will assist you with the day to day management of your diabetes, and your willingness to participate is essential. I, THE APPLICANT acknowledge that my doctor has explained the usage of my diabetes medication to me. I the undersigned, understand that in order for the payment of services to the doctor or service provider to be processed, the medical aid fund will need to know my identity. I hereby consent to the above procedures and that LIFESENSE may send medical information to my treating doctor, medical aid and (courier) pharmacy as required. LIFESENSE and your medical scheme, adhere to the rules of confidentiality as laid out by the Health Professional Council of South Africa. (HPCSA) All personal information collected will be stored in accordance with Protection of Personal Information (POPI) ACT.

APPLICANTS NAME: _____ **APPLICANTS SIGNATURE:** _____

DATE: _____ **PLACE:** _____ **APPLICANTS ID NO.:** _____