Chronic Renal Dialysis

Clinical Information Form

gems
Government Employees Medical Scheme

Date D D M M Y Y Y Y

To Fax

Patient name

Membership no Dependant code

Scheme Option ☐ Tanzanite One ☐ Beryl ☐ Ruby ☐ Emerald Value ☐ Emerald ☐ Onyx

Place of treatment/practice number

Request date D D M M Y Y Y Y

In order to establish the closest network facility, please provide the patient's residential and work address.

Residential address Unit/Apartment no. Complex/Building name

Street no. Street name

Suburb

City Postal code

Telephone (H) Telephone (W)

Mobile no.

Email address

Work address If postal address is the same as residential address - tick box ☐

☐ Private Bag X Number *(complete the number)*

☐ Postnet Suite ☐ Apartment Number *(complete the number)*

Suburb

City Postal code

This member has chosen an option where funding is subject to PMB entry criteria. The following information is needed to assess the member's request for funding.

Please indicate the reason for renal dialysis request: a) Renal failure YES ☐ NO ☐ b) Other reasons e.g. Cardiac.

Please specify _____

Please attach: all reports, laboratory notes and additional information to this form.

1. End stage renal failure when the GFR is <15 ml/min and the patient has one or more of the following symptoms/signs of kidney failure *Neurological signs/symptoms due to uraemia, pericarditis, anorexia, medically resistant acid-based or electrolyte abnormalities, intractable pruritus, serositis, and acid-base or electrolyte abnormalities.*	**YES** ☐	**NO** ☐
2. Inability to control volume status or blood pressure	**YES** ☐	**NO** ☐
3. Progressive deterioration in nutritional status refractory to dietary intervention, or cognitive impairment	**YES** ☐	**NO** ☐
Presence of any of the following: Life expectancy of less than six months or • Severe dementia or • Uncontrollable psychiatric disorder or • Active substance dependency	**YES** ☐	**NO** ☐

Confirmation that none of the following are present: • Life expectancy of less than six months; or • Severe dementia; or • Uncontrollable psychiatric disorder; or • Active substance dependency or • Habitual non-adherence without valid reasons	**YES** ☐	**NO** ☐
4. Please complete the following:		
Is there adequate family support?	**YES** ☐	**NO** ☐
Is the dialysis unit accessible?	**YES** ☐	**NO** ☐
Does the member have transport to attend dialysis sessions?	**YES** ☐	**NO** ☐
Is the member independent and able to function well with activities of daily living (ADL)?	**YES** ☐	**NO** ☐
Is the patient employed?	**YES** ☐	**NO** ☐
Is the employer accommodating of the member's compliance with dialysis sessions?	**YES** ☐	**NO** ☐
5. Provide patient's: Height (m):		Weight (kg):
6. Has the patient tested positive for HBeAg (HepBs Ag)? *Hepatitis serology results must be attached*	**YES** ☐	**NO** ☐
7. Does the patient have cancer?	**YES** ☐	**NO** ☐
Provide detail of the stage, treatment response and prognosis:		
8. Does the patient have any other advanced, irreversible progressive diseases?	**YES** ☐	**NO** ☐
Provide detail of the diagnosis and severity of the disease:		
9. Please list the significant symptoms and signs due to the patient's renal failure		
Signs and symptoms of uremia?	**YES** ☐	**NO** ☐
Presence of diuretic resistant fluid overload?	**YES** ☐	**NO** ☐
Poorly controlled blood pressure?	**YES** ☐	**NO** ☐
Evidence of malnutrition?	**YES** ☐	**NO** ☐
Refractory metabolic acidosis?	**YES** ☐	**NO** ☐
10. What is the patient's current GFR?		
11. Please include a copy of the patients latest renal function test results		

Doctor's signature _____ Date D D M M Y Y Y Y