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. Are there any contraindications or risks associated with the transplantation?	**YES** ☐	**NO** ☐
If Yes, please specify:		
2. Does the patient have HIV? If yes, complete the following:	**YES** ☐	**NO** ☐
Is the member on an anti-retroviral treatment?	**YES** ☐	**NO** ☐
What was the start date of their ARV treatment?	D D M M Y Y Y Y	
Has the patient adhered to the treatment?	**YES** ☐	**NO** ☐
Provide the latest: CD4 count:	Viral load:	
3. Does the patient have an active substance abuse or dependency problem?	**YES** ☐	**NO** ☐

4. Does the patient have a mental illness which could result in diminished capacity to take responsibility for their own actions?			**YES** ☐	**NO** ☐
5. Does the patient have a history of habitual non-adherence with any medical treatment?			**YES** ☐	**NO** ☐
6. 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** ☐
7. Provide patient's:	Height (m):		Weight (kg):	
8. Has the patient tested positive for HBeAg (HepBs Ag)? *Hepatitis serology results must be attached*			**YES** ☐	**NO** ☐
9. Does the patient have cancer?			**YES** ☐	**NO** ☐
Provide detail of the stage, treatment response and prognosis:				
10. Does the patient have any other advanced, irreversible progressive diseases?			**YES** ☐	**NO** ☐
Provide detail of the diagnosis and severity of the disease:				
11. 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** ☐
12. What is the patient's current GFR?				
13. Please include a copy of the patients latest renal function test results				

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

Thank you for providing the above information. We will advise you of the funding decision.

Please return by email: hospitalauths@gems.co.za or fax: 0861 00 4367