Advanced Illness Benefit application form

(To be completed by treating doctor)

Contact details
Tel: 0860 116 116 • PO Box 652509, Benmore 2010 • www.yourremedi.co.za

Who we are

Remedi Medical Aid Scheme (referred to as 'Remedi'), registration number 1430, is the medical scheme that you are currently a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes (CMS).

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Remedi and takes care of the administration of your membership.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. To avoid administration delays, please ensure this application is completed in full and signed by both the doctor and the member (or their proxy).
3. Please return the completed application form to us by email to **consent@yourremedi.co.za**.
4. If you wish to appeal a decision or if you have any questions, you may call our call centre.
5. Please specify the type of information that each third party may have access to and for how long the access should be valid. If you don't specify a date, we will assume the permission to be valid from the date of signature, in section 4 of this form, to continue until you revoke the permission in writing.
6. For more information about how and why we use your information, please view our Privacy Statement: **https://www.yourremedi.co.za/wcm/medical-schemes/remedi/assets/legal/privacy-statement-for-remedi-medical-aid-scheme.pdf**

By signing this application, you confirm that the information provided is true and correct.

1. Patient details

Title | Initials

First name(s)

Surname

Membership number

ID or passport number

Telephone (H) | Telephone (W)

Cellphone

Email

Relationship to main member

2. About the patient's next-of-kin

Title | Initials

Surname

First name(s)
(as per identity document)

Relationship

Cellphone | Telephone

Email

Title | Initials

Surname

First name(s)
(as per identity document)

Relationship

Cellphone Telephone

Email

3. Advance Healthcare Planning

Does the patient have an Advance Care Plan and/or a Living Will? Yes No

If "**Yes**", give the nominated third party's details or the proxy's details:

Title Initials

Surname

First name(s)
(as per identity document)

Relationship

Cellphone Telephone

Email

4. About the referring doctor

Name and surname

BHF Practice number

Speciality

Telephone

Practice address

Suite/Unit number Complex name

Street number Street name

Suburb

City Code

Preferred method of communication Email Post

5. About the treating doctor

Same as above

Name and surname

BHF Practice number

Speciality

Telephone

Suite/Unit number Complex name

Street number Street name

Suburb

City Code

Preferred method of communication Email Post

6. Clinical summary for patients with ADVANCED CANCER ONLY (treating doctor to complete)

Date of assessment D D M M Y Y Y Y

Date of cancer diagnosis D D M M Y Y Y Y **ICD-10 code**

Main cancer diagnosis

Current Stage TNM

TX T0 T1 T2 T3 T4 NX N0 N1 N2 N3 MX M0 M1

If other, please specify:

Metastasis Yes No Unknown

Site of Metastasis Bone Brain Liver Lung

If other, please specify:

Previous chemotherapy, radiotherapy and surgical interventions

Number of unplanned admissions in the past 6 months

Have you and your patient discussed why you are applying for this benefit at this stage? Yes No

Other relevant clinical information

Treatment intent

Palliative

Curative

Disease directed treatment ongoing

Yes

No

If "**Yes**", provide the type of treatment e.g. radiotherapy, chemotherapy. Details:

If **palliative chemotherapy** is planned, provide details of **exact intent** of treatment, e.g. tumour response, improvement in function, symptom control (please specify). Details:

Treatment start date D D M M Y Y Y Y

Planned duration of treatment

If "**No**", provide the date and details of the last treatment

Date D D M M Y Y Y Y

Details:

7. Clinical summary for patients with NON-ONCOLOGY CONDITIONS ONLY (treating Healthcare Professional to complete)

Date of assessment D D M M Y Y Y Y

ICD-10 code

Date of diagnosis D D M M Y Y Y Y

Main diagnosis

Main diagnosis

Number of unplanned admissions in the past six months

Have you and your patient discussed why you are applying for this benefit at this stage?

Treatment to date D D M M Y Y Y Y

Other relevant clinical information including any functional classification scoring system related to the condition e.g NYHA and pathology results

Treatment intent Palliative Curative

8. Performance status (treating doctor to complete for patients ≥ 16 years)*

Current Performance Status*		**Performance Status 6 Months Ago***	
ECOG Performance Status[1]		ECOG Performance Status[1]	
Karnofsky Performance Scale[2]		Karnofsky Performance Scale[2]	

*Refer to page 5 for more information

9. Performance status (treating doctor to complete for patients < 16 years)*

Current Performance status*		**Performance status 6 months ago***	
Lansky Scale[3]		Lansky Scale[3]	

*Refer to page 6 for more information

10. Palliative care plan (treating doctor to complete)

Medication

Item	Dose	Frequency	Duration	Repeat

Other supportive treatment

Social Worker Please specify

Counselling Please specify

Home Nursing (excluding frail care) Please specify

Oxygen		Please specify	
Hospice		Please specify	
Referral to palliative care doctor		Please specify	
Equipment (subject to plan type and review)		Please specify	
Other		Please specify	

Planned date of next assessment D D M M Y Y Y Y

11. Other treating doctors

Name		**Speciality**		**Phone**		**Email**	
Name		**Speciality**		**Phone**		**Email**	

I understand what the Advanced Illness Benefit can offer to the patient and that he/she is comfortable to proceed with registration.

Doctor's signature

Date D D M M Y Y Y Y

By signing consent, I give permission for the identified next-of-kin to be contacted in order for us to assist with the patient's healthcare needs. I understand that as the patient's condition changes, other care treatment plans may be introduced and I give permission for other multidisciplinary healthcare providers to be contacted.

Member/patient or third party/proxy signature on behalf of the member

Date D D M M Y Y Y Y

ECOG Performance Status[1]	Karnofsky Performance Status[2]
0 — Fully active, able to carry on all pre-disease performance without restriction	100 — Normal, no complaints; no evidence of disease 90 — Able to carry on normal activity; minor signs or symptoms of disease
1 — Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work	80 — Normal activity with effort, some signs or symptoms of disease 70 — Cares for self but unable to carry on normal activity or to do active work
2 — Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours	60 — Requires occasional assistance but is able to care for most of personal needs 50 — Requires considerable assistance and frequent medical care
3 — Capable of only limited self-care; confined to bed or chair more than 50% of waking hours	40 — Disabled; requires special care and assistance 30 — Severely disabled; hospitalisation is indicated although death not imminent
4 — Completely disabled; cannot carry on any self-care; totally confined to bed or chair	20 — Very ill; hospitalisation and active supportive care necessary

ECOG Performance Status[1]	Karnofsky Performance Status[2]
	10 — Moribund
5 — Dead	0 — Dead

Karnofsky Performance Status (recipient age ≥ 16 years)[2]	Lansky Scale (recipient age > 1 year and < 16 years)[3]
Able to carry on normal activity, no special care is needed	**Able to carry on normal activity, no special care is needed**
100 — Normal, no complaints; no evidence of disease	100 — Fully active
90 — Able to carry on normal activity; minor signs or symptoms of disease	90 — Minor restriction in physically strenuous play
80 — Normal activity with effort; some signs or symptoms of disease	80 — Restricted in strenuous play, tires more easily, otherwise active
Unable to work, able to live at home, cares for most personal needs, a varying amount of assistance is needed	**Mild to moderate restriction**
70 — Cares for self but unable to carry on normal activity or to do active work	70 — Both greater restrictions of, and less time spent in active play
60 — Requires occasional assistance but is able to care for most of personal needs	60 — Ambulatory up to 50% of time, limited active play with assistance/supervision
50 — Requires considerable assistance and frequent medical care	50 — Considerable assistance required for any active play, fully able to engage in quiet play
Unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly	**Moderate to severe restriction**
40 — Disabled, requires special care and assistance	40 — Able to initiate quiet activities
30 — Severely disabled, hospitalisation is indicated, although death not imminent	30 — Needs considerable assistance for quiet activity
20 — Very ill, hospitalisation and active supportive care necessary	20 — Limited to very passive activity initiated by others (e.g. TV)
10 — Moribund, fatal process progressing rapidly	10 — Completely disabled, not even passive play

1. Sørensen J, Klee M, Palshof T, Hansen H. Performance status assessment in cancer patients. An inter-observer variability study. British journal of cancer. 1993;67(4):773.
2. Schag CC, Heinrich RL, Ganz P. Karnofsky performance status revisited: reliability, validity, and guidelines. Journal of Clinical Oncology. 1984;2(3):187-93.
3. Lansky SB, List MA, Lansky LL, Ritter-Sterr C, Miller DR. The measurement of performance in childhood cancer patients. Cancer. 1987;60(7):1651–6.