Universal Healthcare Provider Networks
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PO Box 1411, Rivonia, 2128

Telephone: +27 11 208 1100 / 0860 111 900
Facsimile: 086 295 7301
E-mail: chronicmedicine@universal.co.za
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NBCRFLI
National Bargaining Council for the Road Freight and Logistics Industry
Your Road Freight Partner.

NBCRFLI CHRONIC MEDICINE APPLICATION FORM

SECTION A: TO BE COMPLETED BY APPLICANT (PLEASE PRINT USING BLOCK LETTERS)

MAIN MEMBER DETAILS

Surname: | First name/s:

ID no/ passport no.:

PATIENT DETAILS

Surname: | First name/s:

Title: | ID no.: | Date of Birth: D D M M Y Y Y Y

NBCRFLI Health Plan

Residential Address:		Postal Address:	
	Postal code:		Postal code:

Telephone no.(H): | Facsimile no.:

Telephone no.(W): | E-mail:

Cell no.:

- I understand that my personal and clinical information will be kept confidential.
- I give permission for my doctor to state the diagnosis of my condition.
- I confirm that the information contained in this application form is correct.

SIGNATURE OF PATIENT

D D M M Y Y Y Y
DATE

SECTION B: TO BE COMPLETED BY THE TREATING DOCTOR. (PLEASE PRINT USING BLOCK LETTERS)

DETAILS OF TREATING DOCTOR

Doctor's name: | Initials: | Qualifying degree:

Practice no.: | HPCSA Reg No.:

Physical Address:		Postal Address:	
	Postal code:		Postal code:

Telephone no.(W): | Facsimile no.:

Cell no.: | E-mail:

SECTION C: TO BE COMPLETED BY THE TREATING DOCTOR. (PLEASE PRINT USING BLOCK LETTERS)

PATIENT'S CLINICAL INFORMATION

Gender: Male | Female Weight : ____ Kg Height : ____ Cms

BMI: ____ Waist circumference: ____ Cms Smoker: YES | NO

Please indicate if the patient has a history of the following:

	YES	NO
Ischaemic Heart Disease		
Peripheral vascular disease		
TIA/Stroke		
First degree relative with premature heart disease; (MI in female <65 years; Males <55 years)		
Familial hyperlipidaemia		

Please provide the following clinical information where applicable:

Latest Blood pressure (sitting, having rested for 5 minutes) ____ / ____ mmHg

Blood glucose results: Random ____ Fasting ____

Lipogram results: Total cholesterol ____ HDL ____ LDL ____

Date: D D M M Y Y Y Y triglyceride ____

COPD: Lung function reports ____

Drug allergies: ____

Please include a copy of lipogram and lung function report if applicable.

SECTION D: TO BE COMPLETED BY TREATING DOCTOR. (PLEASE PRINT USING BLOCK LETTERS)

Please prescribe medicines according to the NBCRFLI Health Plan Formulary.
Diagnosis and medicines for which authorisation is requested.

Diagnosis & ICD10 code	Medicine name	Strength	Directions

- I have verified this application against the Universal Chronic Medicine formulary and the Chronic Condition list
- I hereby declare that the information provided is true and correct

SIGNATURE OF DOCTOR

D D M M Y Y Y Y
DATE

Please return completed application form to NBCRFLI Health Plan: **Fax: 086 295 7301** or **chronicmedicine@universal.co.za**