(To be completed by treating doctor)

# Bankmed

**Contact us** 

Tel: 0800 BANKMED (0800 226 5633), PO Box 1242, Cape Town, 8000, www.bankmed.co.za

### Who we are

Bankmed Medical Scheme (referred to as 'the Scheme'), registration number 1279. This is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07). Discovery Health is responsible for the administration of Bankmed Medical Scheme.

## How to complete this form

- The treating doctor is required to complete the form clearly
- To avoid administration delays, please ensure this application is completed in full and signed by both the doctor and the member (or their proxy)
- Only applications signed by doctors will be accepted
- Kindly return the completed application form to us via e-mail to AIB@bankmed.co.za
- · You and your patient will receive a letter informing you of our decision and what to do next for approved requests
- You may call us should you wish to lodge a formal dispute or if you wish to appeal a decision
- Should you have any questions, you may contact 0800 BANKMED (0800 226 5633)

## 1. About the patient

Title	Initials Surname Surname					
First name(s) (as per iden	tity document)					
Membership number	Date of birth Y Y Y M M D D					
E-mail						
Residential address:						
Suite/Unit number	Complex name					
Street number	Street name					
Suburb	Postal code					
2. About the patient's next-of-kin						
Title	Initials Surname Surname					
First name(s) (as per iden	tity document)					
Relationship						
E-mail						
Cellphone	Telephone					
Does the patient have an Advance Care Plan and/or a Living Will? Yes 🗌 No 🗌						
If "Yes", give the nomi	nated third party's or proxy's details:					
Title	Initials Surname Surname					
First name(s) (as per iden	ity document)					
Relationship						
E-mail						
Cellphone	Telephone					

3. About the referring doctor																																							
Name and surname																																							
BHF practice number																																							
Speciality																																							
Telephone						]																				F	ах												
Preferred method of co	mmur	nica	atio	n																																			
E-mail																																							
Practice address																																		_					
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Name and surname														Τ					Γ										Т		Т								
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Date of cancer diagnosis		0	-	Y	N	/ I	VI E	)	D																														
Main cancer diagnosis			-																																				
Current Stage TNM																																							
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Describe other																																							
Metastasis	Yes [		No		[			Un	kno	wn																													
Site of Metastasis	Bone [		Bra	in	Ľ			Liv	er			L	ung	g [			01	the	er (j	plea	ase	sp	ecif	y)															
Previous chemotherapy	, radio	oth	era	ру	an	d s	urgi	cal	inte	erv	enti	on	S																										
Other relevant clinical information																																							
Treatment intent Palliative Curative																																							
Disease directed treatm									] No										Г																				
If " <b>Yes</b> ", provide the typ	be of t	rea	atm	en	t e	g ra	dio	the	erap	y, (	chei	no	the	rap	oy.	D	eta	ails	: [																				
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## 5. Clinical summary for patients with ADVANCED CANCER ONLY (treating doctor to complete) (continued)

If palliative chemotherapy planned, provide details of exact intent of treatment, eg tumour response, improvement in function, symptom control

(please specify). Details:							
[							
Treatment start date							
Planned duration of treatment	nt						
If "No", provide the date and details of the last treatment.							
Date	Y Y Y M M D D						
Details							
6 Clinical summary f	or patients with NON-ONCOLOGY CONDITIONS ONLY (treating doctor to complete)						
Date of assessment <b>Main Diagnosis</b>							
Date of diagnosis $\boxed{\begin{array}{c} & & \\ & & \\ \end{array}}$	( Y M M □ □ ICD-10 code						
Number of unplanned admis							
Have you and your patient di	iscussed why you are applying for this benefit now?						
Treatment to date							
Other relevant clinical inform	nation including any functional classification scoring system related to the condition eg NYHA and pathology results						
Treatment intent Pallia	ative Curative						

# 7. Performance status (treating doctor to complete)

Current Performance status*	Performance status 6 months ago*					
ECOG Performance Status 1	ECOG Performance Status 1					
Karnofsky Performance Scale <sup>2</sup>	Karnofsky Performance Scale <sup>2</sup>					

\*Refer to page 4 for more information

## 8. Palliative care plan (treating doctor to complete)

Medication								
Item	Dose	Frequency	Duration	Repeat				
Other treatment								

Planned date of next assessment 2 0 Y M M D

## 9. Other treating doctors

Name:	Speciality:	Phone:	E-mail:
Name:	Speciality:	Phone:	E-mail:

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

Doctor's Signature	Date 2 0 Y M M D	D
Member's signature or third party proxy signature on behalf of the member	Date 2 0 Y M M D	D

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	80—Normal activity with effort, some signs or symptoms of disease
carry out work of a light or sedentary nature, e.g., light house work, office work	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	40—Disabled; requires special care and assistance
than 50% of waking hours	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
	10—Moribund
5—Dead	0—Dead

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.

Bankmed Medical Scheme is a registered medical scheme with the Council for Medical Schemes (CMS). The CMS contact details are as follows: e-mail complaints@medicalschemes.com / Customer Care Centre: 0861 123 267 / website www.medicalschemes.com

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