Contact us
Tel: 0800 BANKMED (0800 226 5633) • Private Bag X2, Rivonia 2128 • www.bankmed.co.za

Advanced Illness Benefit & Compassionate Care Benefit application form

(To be completed by treating Healthcare Professional)

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.

Purpose of the form

This form is to apply for palliative care through the Advanced Illness Benefit or the Compassionate Care Benefit.

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 Healthcare Professional and the member (or their proxy).
3. Fill in section 1 to 3 of the application form and sign section 11.
4. Take the form to your treating Healthcare Professional to complete section 4 to 11. Only applications signed by the treating Healthcare Professional will be accepted.
5. Please e-mail this completed and signed form to **AIB@bankmed.co.za**
6. The treating Healthcare Professional and the patient will receive a letter informing them of our decision and what to do next for approved requests.
7. If you wish to appeal a decision or if you have any questions, you may call our Call Centre on 0800 BANKMED (0800 226 5633).

Date of application D D M M Y Y Y Y

1. About the patient

Title | Initials | Surname

First name/s (as per identity document)

Membership number | Date of birth D D M M Y Y Y Y

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

First name/s (as per identity document)

Relationship

E-mail

Cellphone | Telephone

Title | Initials | Surname

First/s name (as per identity document)

Relationship

E-mail

Cellphone

Telephone

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

E-mail

Cellphone

Telephone

4. About the referring Healthcare Professional

Name and surname

BHF practice number

Speciality

Telephone

Fax

Preferred method of communication

E-mail

Practice address

Code

5. About the treating Healthcare Professional

Same as above

Name and surname

BHF practice number

Speciality

Telephone

Fax

Preferred method of communication

E-mail

Practice address

Code

6. Clinical summary for patients with ADVANCED CANCER ONLY (treating Healthcare Professional 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

Describe other

BANAIB001

Metastasis Yes ☐ No ☐ Unknown ☐

Site of Metastasis Bone ☐ Brain ☐ Liver ☐ Lung ☐ 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 eg radiotherapy, chemotherapy. Details:

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 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

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

Main Diagnosis

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 ☐

Treatment to date

BANAIB001

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 Healthcare Professional 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 6 for more information

9. Performance status (treating Healthcare Professional 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 Healthcare Professional 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 Healthcare Professional	☐	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 Healthcare Professionals

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

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

Healthcare Professional'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 Professionals 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 care 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 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 90— Able to carry on normal activity, minor signs or symptoms of disease 80—Normal activity with effort, some signs or symptoms of disease	100—Fully active 90—Minor restriction in physically strenuous play 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 60— Requires occasional assistance but is able to care for most of personal needs 50—Requires considerable assistance and frequent medical care	70— Both greater restrictions of, and less time spent in active play 60— Ambulatory up to 50% of time, limited active play with assistance/supervision 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 30— Severely disabled, hospitalisation is indicated, although death not imminent 20—Very ill, hospitalisation and active supportive care necessary 10—Moribund, fatal process progressing rapidly	40— Able to initiate quiet activities 30— Needs considerable assistance for quiet activity 20— Limited to very passive activity initiated by others (e.g. TV) 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.