

## Application form for wound care 2022

### Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, 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) which takes care of the administration of your membership for the Scheme.

### Purpose of the form

This application form is for when a member needs wound management therapy. We will only consider funding requests from the member's treating Healthcare Professional, who must complete the application form. Applications from a manufacturer will not be accepted.

### What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally by using Adobe Acrobat Reader.
- All relevant sections must be physically signed by the main applicant and cannot be signed digitally. The main applicant must sign and date any changes.
- Please send the form and photographs to us by e-mail at [treatment@bankmed.co.za](mailto:treatment@bankmed.co.za)

### 1. Patient's details

Title	<input type="text"/>	Initials	<input type="text"/>	Surname	<input type="text"/>
First name(s) (as per identity document)	<input type="text"/>				
Preferred name	<input type="text"/>	Gender	M <input type="checkbox"/>	F <input type="checkbox"/>	
Date of birth	<input type="text"/>	ID or passport number	<input type="text"/>		
Country of issue	<input type="text"/>				
Membership number	<input type="text"/>				
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>	<input type="text"/>	
Cellphone	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	
E-mail	<input type="text"/>				

### 2. Proposed treatment facility details

Referring Healthcare Professional's practice number	<input type="text"/>
Treating Healthcare Professional's practice number	<input type="text"/>

### 3. Current medical status

Aetiology / Cause	<input type="text"/>				
Nutritional information	Obesity <input type="checkbox"/>	Malnutrition <input type="checkbox"/>	Dehydration <input type="checkbox"/>	Weight loss >5kg <input type="checkbox"/>	Weight gain >5kg <input type="checkbox"/>
	Loss of Appetite <input type="checkbox"/>	Supplements <input type="checkbox"/>			
Mobility	Good Mobility <input type="checkbox"/>	Bad Mobility <input type="checkbox"/>			
Mental Status	Orientated <input type="checkbox"/>	Depressed <input type="checkbox"/>	Anxious <input type="checkbox"/>	Comatose <input type="checkbox"/>	Stressed <input type="checkbox"/>

**Medical Concerns**

Smoking

**Medical condition**

ICD-10 code  -

Stroke <input type="checkbox"/>	Varicose Veins <input type="checkbox"/>	Gangrene <input type="checkbox"/>	Artherosclerosis <input type="checkbox"/>
Asthma <input type="checkbox"/>	COPD <input type="checkbox"/>	Bronchitis <input type="checkbox"/>	Parkinson's <input type="checkbox"/>
Alzheimer's <input type="checkbox"/>	Quadriplegia <input type="checkbox"/>	Paraplegia <input type="checkbox"/>	Hep B <input type="checkbox"/>
Spinal problems <input type="checkbox"/>	Porphyria <input type="checkbox"/>	Anaemia <input type="checkbox"/>	Cancer <input type="checkbox"/>
Chemotherapy <input type="checkbox"/>	Radiotherapy <input type="checkbox"/>	Swollen Glands <input type="checkbox"/>	DVT <input type="checkbox"/>
Lymphoedema <input type="checkbox"/>	Neuropathy <input type="checkbox"/>	Previous Amputations <input type="checkbox"/>	Alternative Treatments <input type="checkbox"/>
Oedema <input type="checkbox"/>	Bowel Problems <input type="checkbox"/>	Renal Problems <input type="checkbox"/>	Immune Deficient <input type="checkbox"/>

Diabetes Type I  Type II

Circulation problems Arterial  Venous

Other

Allergies

Medication

**4. Clinical Measurement**

Height	Weight	BP	Pulse
HbA1c	Random BG	Temp	
Other	<input type="text"/>		
	<input type="text"/>		

## 5. History of previous advanced or conservative wound treatment


## 6. Wound location

ICD-10 codes

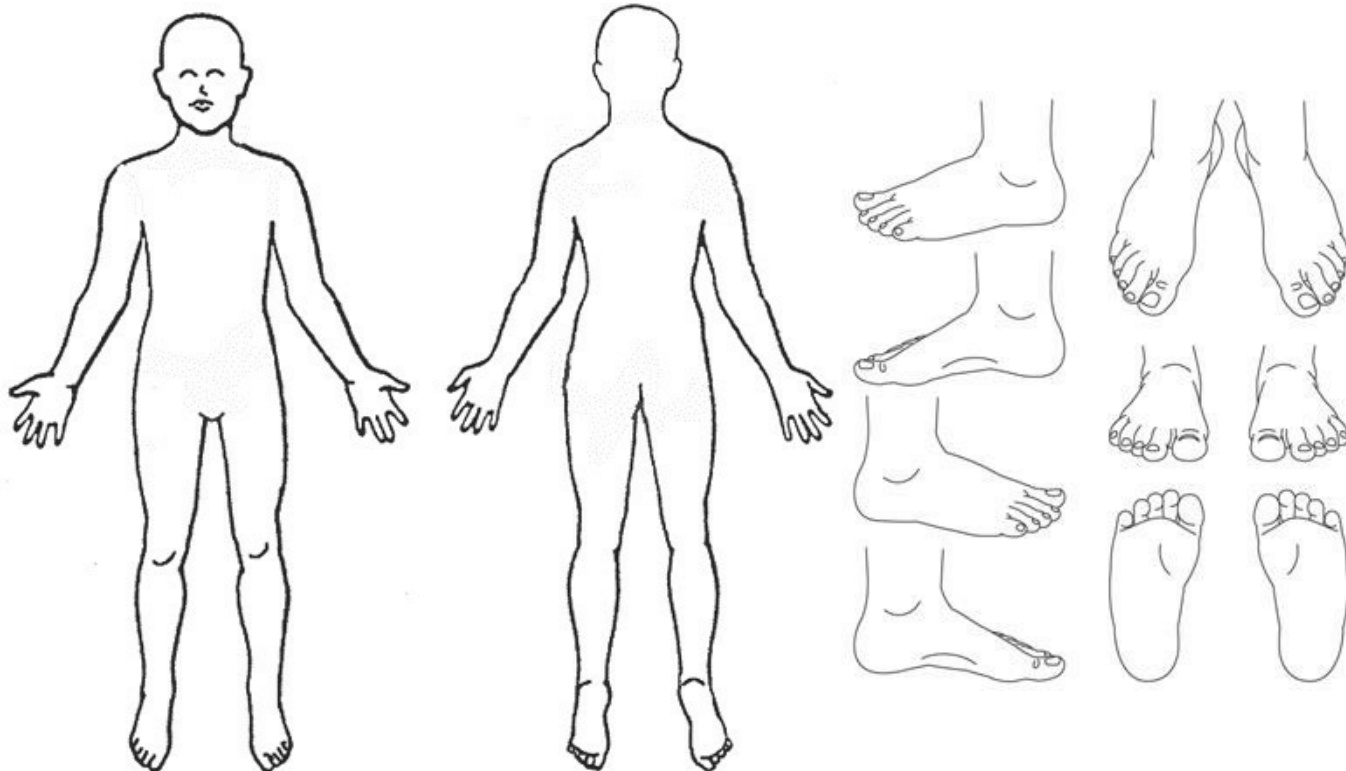
				-			
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Date wound first occurred

D	D	M	M	Y	Y	Y	Y
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Treatment start date

D	D	M	M	Y	Y	Y	Y
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## 7. Wound description

Diabetic ulcer	<input type="checkbox"/>	Enterocutaneous fistula	<input type="checkbox"/>	Post- surgical wound	<input type="checkbox"/>	Ostomy	<input type="checkbox"/>
Pressure ulcer	<input type="checkbox"/>	Leg ulcer	<input type="checkbox"/>	Venous (CEAP)	<input type="checkbox"/>	Arterial	<input type="checkbox"/>
Mixed	<input type="checkbox"/>	Dermatological condition	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Burns (rule of 9)	<input type="checkbox"/>

## TEXAS Classification

STAGE	GRADE			
	0	I	II	III
A	Pre- or post-ulcerative lesion completely epithelialized	Superficial wound not involving tendon, capsule or bone	Wound penetrating to tendon or capsule	Wound penetrating to bone or joint
B	Infection	Infection	Infection	Infection
C	Ischemia	Ischemia	Ischemia	Ischemia
D	Infection and Ischemia	Infection and Ischemia	Infection and Ischemia	Infection and Ischemia

**CEAP Classification**

C0	C1	C2	C3	C4	C5	C6
No visible or palpable signs of venous disease	Telangiectasias or reticular veins	Varicose veins	Oedema	a. Pigmentation and/ or eczema b. Lipodermatosclerosis and/or atrophie blanche	Healed Venous Ulcer	Active Venous Ulcer

**Pressure ulcers staging**

Stage 1	Stage 2	Stage 3	Stage 4	Un-stageable	Deep tissue injury
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**Burns**

First degree  Second degree  Third degree

RULE OF 9 ADULT		PERCENTAGE		RULE OF 9 CHILD		PERCENTAGE	
Head and neck		9		Head and neck		18	
Anterior trunk		18		Anterior trunk		18	
Posterior trunk		18		Posterior trunk		18	
		<b>L</b>	<b>R</b>			<b>L</b>	<b>R</b>
Upper extremities		9	9	Upper extremities		9	9
Lower extremities		18	18	Lower extremities		14	14
Genitalia and perineum		1		Genitalia and perineum		1	

**Ability to Heal**

Healable wound  Maintenance Wound  Non-Healable / Palliative Wound

Other

Site of wound  Size of wound

Length  Width  Depth

Volume  Undermining / sinus

**Wound bed condition (100%)**

Epithelialisation  Granulation  Slough / Fibrin  Black / Brown Necrotic Tissue

Over Granulating  Fungating / Malignant  Mixed Tissue (Bone/Tendon/Ligament)

**Infection**

Colonised  **N E R D S**  Superficial  **S T O N E S**

Deep  Biofilm

Odour Yes  No

**Amount and colour of Exudate**

Colour Yes  No

Amount (ml)

	Amount		
	Low	Moderate	High
Serous (clear thin watery)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sanguineous (fresh blood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serosanguineous (watery pale pink)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Purulent (creamy, yellow, brown, green)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Conditions of surrounding skin

Healthy / Intact       Dry / Cracked / Eczema       Discoloured       Erythema / fragile / Inflamed   
 Macerated       Callous / Senescent cells       Oedematous

#### Wound healing phase

Inflammatory       Proliferation       Maturation

#### Pain assessment

Severity	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>	4	<input type="checkbox"/>	5	<input type="checkbox"/>	6	<input type="checkbox"/>	7	<input type="checkbox"/>	8	<input type="checkbox"/>	9	<input type="checkbox"/>	10	<input type="checkbox"/>
Frequency	At dressing stage				On Movement				Continuous				Other									

### 8. Treatment goal

#### Short term

#### Long term

Wound closure  
 Debride necrotic tissue  
 Reduce Bacterial load  
 Treat Infection  
 Encourage granulation  
 Reduced wound size and severity  
 Moisture balance  
 Reduce Oedema

### 9. Treatment plan

Referring Healthcare Professional's name	<input type="text"/>
Practice number	<input type="text"/>
Treating Healthcare Professional's name	<input type="text"/>
Practice number	<input type="text"/>
Treatment start date	<input type="text"/>
Number of treatments	<input type="text"/>

#### Multidisciplinary team

GP       Orthopaedic surgeon       Vascular surgeon       General surgeon   
 Podiatrist       Diabetes Educator       Specialist physician       Wound management specialist

**Treatment period**Treatment date 1 

D	D	M	M	Y	Y	Y	Y
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Treatment date 2 

D	D	M	M	Y	Y	Y	Y
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Treatment date 3 

D	D	M	M	Y	Y	Y	Y
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Treatment date 4 

D	D	M	M	Y	Y	Y	Y
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Treatment date 5 

D	D	M	M	Y	Y	Y	Y
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Treatment date 6 

D	D	M	M	Y	Y	Y	Y
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Treatment date 7 

D	D	M	M	Y	Y	Y	Y
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Treatment date 8 

D	D	M	M	Y	Y	Y	Y
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**10. Treatment plan details**

NAPPI code	Product code	Product description	Quantity	Total price

**11. Professional fees: quotation**

Tariff code	Service	Fee, incl VAT	Number of procedures	Total fee

**12. Additional products used**

NAPPI code	Product code	Product description	Price number of applications	Total price

**13. Photograph****Checklist**Colour Include a ruler in photo to illustrate size Please date the photo(s) chronologically 

Signature of Healthcare Professional

Date 

D	D	M	M	Y	Y	Y	Y
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**Please only sign if information is true, complete and correct.**