

## Application form for wound care 2024

### 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 required 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

1. Fill in the form in black ink and print clearly, or complete the form digitally using Adobe Acrobat Reader.
2. 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.
3. 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"/>	Initial(s)	<input type="text"/>
Surname	<input type="text"/>		
First name(s)	<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"/>		
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Telephone (W)	<input type="text"/>
Cellphone	<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

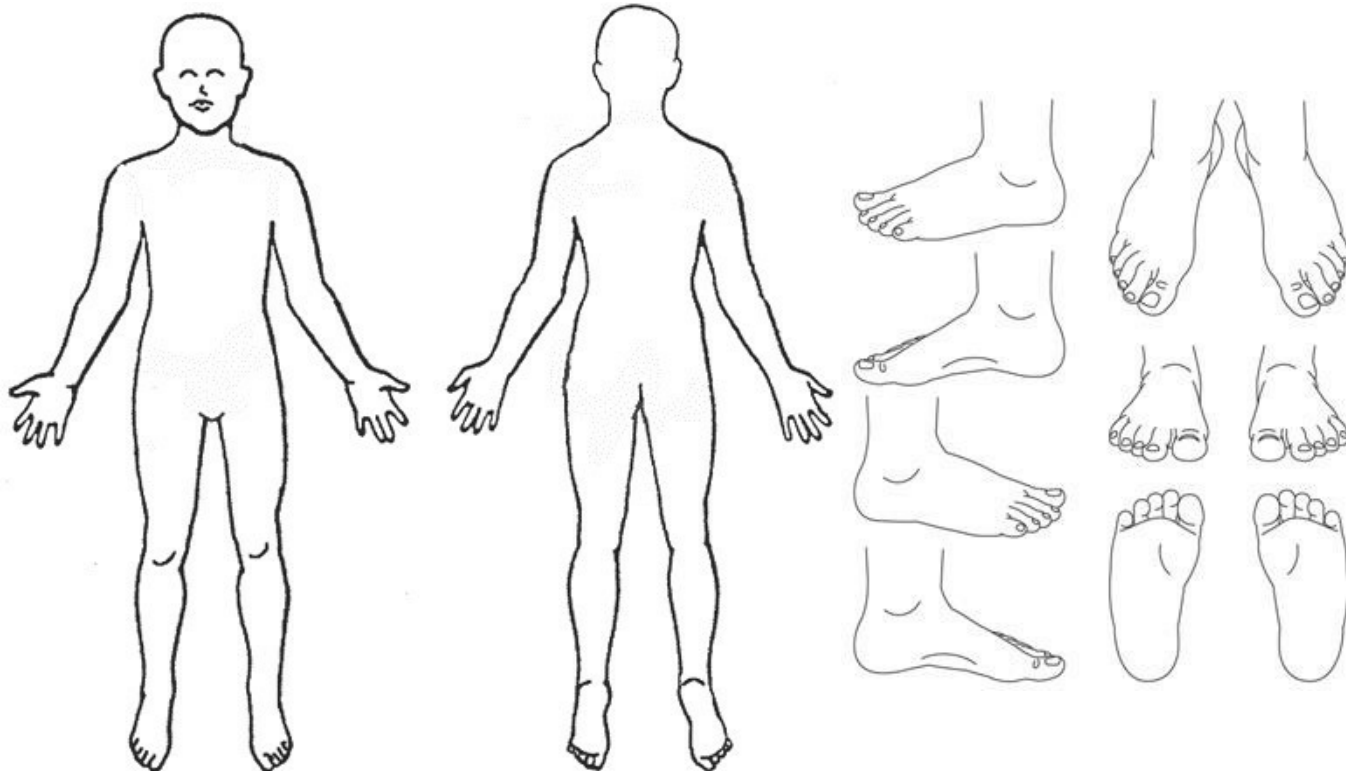
				-			
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Date wound first occurred

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 epithelialised	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**   
**Practice number**

**Treating Healthcare Professional's name**   
**Practice number**

**Treatment start date**

**Number of treatments**

### 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

Date 

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