

Chronic Renal Dialysis

Clinical Information Form



Date

To Fax

Patient name

Membership no Dependant code

Scheme Option Tanzanite One Beryl Ruby Emerald Value Emerald Onyx

Place of treatment/practice number

Request date

In order to establish the closest network facility, please provide the patient's residential and work address.

Residential address Unit/Apartment no. Complex/Building name

Street no. Street name

Suburb

City Postal code

Telephone (H) Telephone (W)

Mobile no.

Email address

Work address If postal address is the same as residential address - tick box

Private Bag X Number (*complete the number*)

Postnet Suite Apartment Number (*complete the number*)

Suburb

City Postal code

This member has chosen an option where funding is subject to PMB entry criteria. The following information is needed to assess the member's request for funding.

Please indicate the reason for renal dialysis request: a) Renal failure YES NO b) Other reasons e.g. Cardiac.

Please specify _____

Please attach: all reports, laboratory notes and additional information to this form.

1. Are there any contraindications or risks associated with the transplantation?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<i>If Yes, please specify:</i>			
2. Does the patient have HIV? If yes, complete the following:		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the member on an anti-retroviral treatment?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
What was the start date of their ARV treatment?		<input type="text" value="DDMMYYYY"/>	
Has the patient adhered to the treatment?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Provide the latest:	CD4 count:		Viral load:

3. Does the patient have an active substance abuse or dependency problem?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Does the patient have a mental illness which could result in diminished capacity to take responsibility for their own actions?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Does the patient have a history of habitual non-adherence with any medical treatment?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
6. Please complete the following:			
Is there adequate family support?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the dialysis unit accessible?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does the member have transport to attend dialysis sessions?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the member independent and able to function well with activities of daily living (ADL)?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the patient employed?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is the employer accommodating of the member's compliance with dialysis sessions?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
7. Provide patient's:	Height (m):		Weight (kg):
8. Has the patient tested positive for HBeAg (HepBs Ag)? <i>Hepatitis serology results must be attached</i>		YES <input type="checkbox"/>	NO <input type="checkbox"/>
9. Does the patient have cancer?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<i>Provide detail of the stage, treatment response and prognosis:</i>			
10. Does the patient have any other advanced, irreversible progressive diseases?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
<i>Provide detail of the diagnosis and severity of the disease:</i>			
11. Please list the significant symptoms and signs due to the patient's renal failure			
Signs and symptoms of uremia?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Presence of diuretic resistant fluid overload?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Poorly controlled blood pressure?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Evidence of malnutrition?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Refractory metabolic acidosis?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
12. What is the patient's current GFR?			
13. Please include a copy of the patients latest renal function test results			

Doctor's signature _____

Date

D	D	M	M	Y	Y	Y	Y
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