ONCOLOGY BENEFIT APPLICATION FORM

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SOVEREIGN HEALTH

67 OLD FORT ROAD DURBAN 4001
P O BOX 2338 DURBAN 4000

First motivation ☐ **Renewal of application** ☐ **Change** ☐

Medical Aid: _________________

Medical Aid Number : ______________________________

Member Name : ______________________________

Patient Name : ______________________________

Date of Birth : ______________________________

Practice Ref. No.: ______________ Member / Relative Tel No. : ______________________________

Diagnosis: ____ Stage: _______________________

Date of Diagnosis: _____________________________ Performance Status: ____________(ECOG 0-4)

Brief clinical history / Mode of Diagnosis: ____

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Previous chemotherapy/radiotherapy used: YES / NO

Pathology and radiology tests to be done whilst on treatment: ___________________________________

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Chemotherapy Treatment Details:

Treatment regime proposed: ______________________________ Commencement date: _____________

______________________________ Palliative / Curative: ______________

______________________________ Inpatient / Outpatient: _____________

No. of cycles: ________________Intervals: _________________Cost per cycle: ___________________

Product Name	Daily Dose	Strength	Quantity	Days of Cycle

Radiotherapy Treatment Details:

Treatment Area	Technique	Dose / Fraction	Fraction No.	Total Dose

Estimated Cost: Doctor ________________________________ Hospital: __________________________

Practice No.: ______________________

Practice No.: ____________________________ Full Name: ____________________________________

Signature: ________________ Contact Person: ______________________ Tel. No.: _______________