

Advanced Illness Benefit application form 2022

(To be completed by treating doctor)



Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, www.discovery.co.za, PO Box 784262, Sandton, 2146, 1 Discovery Place, Sandton, 2196.

Purpose of the form

This form is to apply for palliative care through the Advanced Illness Benefit (AIB) for both advanced oncology (cancer) or for non-oncology conditions.

If the member is not able to complete the form, their proxy must sign it. You can find the **Permission to make certain information available to a third party form** on www.discovery.co.za > Manage your health plan > Find a document > Application forms.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed by both the treating doctor and the member/patient or their proxy and cannot be signed digitally. The member/patient or proxy must sign and date any changes.
- Fill in section 1 to 3 of the application form and sign section 11.
- Take the form to your treating doctor to complete section 4 to 11. Only applications signed by the treating doctor will be accepted.
- Please return the completed application form to us by email to AIB@discovery.co.za.
- The treating doctor and the patient will receive a letter informing them of our decision and what to do next for approved requests.
- You may call us if you would like to lodge a formal dispute or if you wish to appeal a decision.

Date of application

D	D	M	M	Y	Y	Y	Y
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1. Patient details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Membership number	<input type="text"/>	Date of birth	<input type="text"/> - <input type="text"/> - <input type="text"/>
Telephone (H)	<input type="text"/> - <input type="text"/>	Telephone (W)	<input type="text"/> - <input type="text"/>
Cellphone	<input type="text"/> - <input type="text"/>		
Email	<input type="text"/>		

Residential Address:

Suite/Unit number	<input type="text"/>	Complex name	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>	Code	<input type="text"/>

2. Patient's next of kin details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Relationship	<input type="text"/>		
Email	<input type="text"/>		
Cellphone	<input type="text"/> - <input type="text"/>	Telephone	<input type="text"/> - <input type="text"/>
Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Relationship	<input type="text"/>		
Email	<input type="text"/>		
Cellphone	<input type="text"/> - <input type="text"/>	Telephone	<input type="text"/> - <input type="text"/>

3. Advance Health Care Planning

Does the patient have an Advance Care Plan and/or a Living Will? Yes No

**A living will is a legal document that sets out your wishes for your healthcare when you cannot share them yourself. It guides your family and healthcare providers when you are not in a condition to make decisions or express your wishes.*

If "Yes", give the nominated third party's details or the proxy's details.

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Relationship	<input type="text"/>		
Email	<input type="text"/>		
Cellphone	<input type="text"/> - <input type="text"/>	Telephone	<input type="text"/> - <input type="text"/>

4. About the referring doctor

Name and surname	<input type="text"/>		
BHF practice number	<input type="text"/>		
Speciality	<input type="text"/>		
Telephone	<input type="text"/> - <input type="text"/>		
Email	<input type="text"/>		
Preferred method of communication	<input type="text"/>		
Practice address	<input type="text"/>		Code <input type="text"/>

5. About the treating doctor

Same as above

Name and surname

BHF practice number

Speciality

Telephone -

Preferred method of communication

Email

Practice address

Code

6. Clinical summary for patients with ADVANCED CANCER ONLY (treating doctor to complete)

Date of assessment - -

Date of cancer diagnosis - - ICD-10 code

Main cancer diagnosis

Current Stage TNM

TX T0 T1 T2 T3 T4 NX N0 N1 N2 N3 MX M0 M1

If other, please specify:

Metastasis Yes No Unknown

Site of Metastasis Bone Brain Liver Lung

If other, please specify:

Previous chemotherapy, radiotherapy and surgical interventions

Number of unplanned admissions in the past six 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 e.g. radiotherapy, chemotherapy.

Details:

If **palliative chemotherapy** is planned, provide details of **exact intent** of treatment, e.g. tumour response, improvement in function, symptom control (Please specify).

Details:

Treatment start date

D	D	-	M	M	-	Y	Y	Y	Y
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Planned duration of treatment

If **"No"**, provide the date and details of the last treatment.

Date

D	D	-	M	M	-	Y	Y	Y	Y
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7. Clinical summary for patients with NON-ONCOLOGY CONDITIONS (treating doctor to complete)

Date of assessment

D	D	-	M	M	-	Y	Y	Y	Y
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Date of diagnosis

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

ICD-10 code

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Main diagnosis

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Number of unplanned admissions in the past six months

--

Have you and your patient discussed why you are applying for this benefit at this stage? Yes No

Treatment to date

--

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 doctor to complete for patients ≥ 16 years)*

Current Performance status*		Performance status 6 months ago*			
ECOG Performance Status ¹	<table border="1"><tr><td> </td></tr></table>		ECOG Performance Status ¹	<table border="1"><tr><td> </td></tr></table>	
Karnofsky Performance Scale ²	<table border="1"><tr><td> </td></tr></table>		Karnofsky Performance Scale ²	<table border="1"><tr><td> </td></tr></table>	

*Refer to page 7 for more information

9. Performance status (treating doctor to complete for patients < 16 years)*

Current Performance status*		Performance status 6 months ago*			
Lansky Scale ³	<table border="1"><tr><td> </td></tr></table>		Lansky Scale ³	<table border="1"><tr><td> </td></tr></table>	

*Refer to page 7 for more information

10. Palliative care plan (treating doctor to complete)

Medicine

Item	Dose	Frequency	Duration	Repeat

Other supportive treatment

- Social Worker Please specify
- Counselling Please specify
- Home Nursing Please specify
- (excluding frail care)
- Oxygen Please specify
- Hospice Please specify
- Referral to palliative care doctor Please specify
- Equipment Please specify
- (subject to plan type and review)
- Other Please specify

Planned date of next assessment / - / - / / /

11. Other treating doctors

Name	Speciality	Phone	Email

I understand what the Advanced Illness Benefit (AIB) can offer to the patient and that the patient is comfortable to proceed with registration.

Signature of doctor

Date - -



Please only sign if information is true, complete and correct.

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 providers to be contacted.

Member / patient / third party / proxy
signature on behalf of the patient

Date - -



Please only sign if information is true, complete and correct.

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 needs 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.