

Advanced Illness Benefit application form

(To be completed by the patient and their treating doctor and must be signed by the principal member)

Who we are

Engen Medical Benefit Fund, referred to as 'the Fund', registration number 1572, is the medical scheme that you are a member of. The Fund is a not-for-profit organisation, registered with the Council for Medical Schemes as a medical scheme. Discovery Health (Pty) Ltd, referred to as 'the Administrator', is a separate company and an authorised financial services provider (registration number 1997/013480/07). We take care of the administration of your membership for the Fund.

Purpose of the form

This form is to apply for palliative care through the Advanced Illness Benefit (AIB).

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly. Alternatively, complete it digitally.
2. To avoid administration delays, please ensure this application is completed in full and signed by both the doctor and the member (or their proxy).
3. Fill in section 1 to 3 of the application form and sign section 11.
4. Your treating doctor needs to complete section 4 to 11. Only applications signed by the treating doctor will be accepted.
5. Please email this completed and signed form to AIB@discovery.co.za.
6. The treating doctor and the patient will receive a letter with the final decision, and what to do next, for approved requests.

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)	<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"/>		
Email	<input type="text"/>		
Physical address	<input type="text"/>		
Unit/Suite number	<input type="text"/>	Complex/Building	<input type="text"/>
Street number	<input type="text"/>	Street name	<input type="text"/>
Suburb	<input type="text"/>		
City	<input type="text"/>	Postal code	<input type="text"/>

2. About the patient's next-of-kin

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"/>		
Cellphone	<input type="text"/>	Telephone	<input type="text"/>
Email	<input type="text"/>		

Title Initials

Surname

First name(s) (as per identity document)

Relationship

Cellphone Telephone

Email

3. Advance Care Planning

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

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

Title Initials

Surname

First name(s) (as per identity document)

Relationship

Cellphone Telephone

Email

4. About the referring doctor

Name and Surname

BHF practice number Speciality

Telephone

Email

5. About the treating doctor

Same as above

Name and surname

BHF practice number Speciality

Telephone

Email

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 6 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, targeted therapy. 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

Planned duration of treatment

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

Date

Details

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

Date of assessment

Date of diagnosis

ICD-10 code

Main Diagnosis

Number of unplanned admissions in the past 6 months

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

Treatment to date

Relevant clinical information including any functional classification scoring system related to the condition e.g., NYHA and pathology results, symptoms

Treatment intent Palliative Curative

8. Performance status (treating doctor to complete for patients ≥ 16 years)*

Current Performance status*

Performance status 6 months ago*

Current Performance status*	Performance status 6 months ago*
ECOG Performance Status ¹	ECOG Performance Status ¹
Karnofsky Performance Scale ²	Karnofsky Performance Scale ²

*Refer to page 6 for more information

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

Current Performance status*

Performance status 6 months ago*

Lansky Scale ³

Lansky Scale ³

*Refer to page 6 for more information

10. Palliative care plan (treating doctor to complete)

Medicine

Item	Dose	Frequency	Duration

Other supportive treatment

- Social worker Please specify
- Counselling Please specify
- Home nursing (excluding frail care) Please specify
- Oxygen Please specify
- Hospice Please specify
- Referral to palliative care doctor Please specify
- Bed rentals (subject to plan type and review) Please specify
- Other Please specify

Planned date of next assessment

11. Other treating doctors

Name

Practice number Speciality

Telephone

Email

Name

Practice number Speciality

Telephone

Email

I understand what the Advanced Illness Benefit can offer to the patient and that they are comfortable to proceed with registration.

Doctor's Signature Date

By signing consent, I give permission / give permission on their behalf for the identified next-of-kin to be contacted to allow 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 or third party/proxy signature on behalf of the patient

Date

D	D	M	M	Y	Y	Y	Y
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ECOG Performance Status ¹	Karnofsky Performance Status ²
0 — Fully active, able to carry on all pre-disease performance with-out 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 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	Able to carry on normal activity, no special care is needed 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 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	Mild to moderate restriction 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 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	Moderate to severe restriction 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.