

**Contact details**

Tel: 0860 123 077 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

**Advanced Illness Benefit application form**

(To be completed by treating doctor)

**Who we are**

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, 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). We take care of the administration of your membership for the Scheme.

**Purpose of the form**

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

**How to complete this form**

1. Please use one letter per block, complete in black ink and print clearly.
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. Take the form to your treating doctor to complete section 4 to 11. Only applications signed by the treating doctors 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 informing them of our decision and what to do next for approved requests.
7. If you wish to appeal a decision or if you have any questions, you may call our call centre.

Date of application        **1. About the patient**Title     Initials     Surname First name(s) (as per identity document) Membership number             Date of birth        Email Cellphone         Telephone        **Residential address:**Suite/Unit number     Complex name Street number     Street name Suburb         Code    **2. About the patient's next-of-kin**Title     Initials     Surname First name(s) (as per identity document) Relationship Email Cellphone         Telephone        Title     Initials     Surname

First name(s) (as per identity document)

Relationship

Email

Cellphone           Telephone

### 3. Advance Healthcare Planning

Does the patient have an Advance Care Plan and/or a 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

Email

Cellphone           Telephone

### 4. About the referring doctor

Name and surname

BHF Practice number

Speciality

Telephone

Preferred method of communication

Email

Practice address

Code

### 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 

D	D	M	M	Y	Y	Y	Y
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Date of cancer diagnosis 

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

 ICD-10 code 

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Main cancer diagnosis 

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

If other, please specify: 

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Metastasis Yes  No  Unknown

Site of Metastasis Bone  Brain  Liver  Lung

If other, please specify: 

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Previous chemotherapy, radiotherapy and surgical interventions  


Number of unplanned admissions in the past 6 months 

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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
---	---	---	---	---	---	---	---

  
 Planned duration of treatment 

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

D	D	M	M	Y	Y	Y	Y
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Details:  


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

Date of assessment 

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

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 6 months 

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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 <sup>1</sup>		ECOG Performance Status <sup>1</sup>	
Karnofsky Performance Scale <sup>2</sup>		Karnofsky Performance Scale <sup>2</sup>	

\*Refer to page 6 for more information

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

Current Performance status*		Performance status 6 months ago*	
Lansky Scale <sup>3</sup>		Lansky Scale <sup>3</sup>	

\*Refer to page 6 for more information

**10. Palliative care plan (treating doctor to complete)**

Medication

Item	Dose	Frequency	Duration	Repeat

**Other supportive treatment**

Social Worker	<input type="checkbox"/>	Please specify	<input type="text"/>
Counselling	<input type="checkbox"/>	Please specify	<input type="text"/>
Home Nursing (excluding frail care)	<input type="checkbox"/>	Please specify	<input type="text"/>
Oxygen	<input type="checkbox"/>	Please specify	<input type="text"/>
Hospice	<input type="checkbox"/>	Please specify	<input type="text"/>
Referral to palliative care doctor	<input type="checkbox"/>	Please specify	<input type="text"/>
Equipment (subject to plan type and review)	<input type="checkbox"/>	Please specify	<input type="text"/>
Other	<input type="checkbox"/>	Please specify	<input type="text"/>


Planned date of next assessment 

D	D	M	M	Y	Y	Y	Y
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**11. Other treating doctors**

Name	Speciality	Phone	Email

I understand what the Advanced Illness Benefit can offer to the patient and that he/she is comfortable to proceed with registration.

Doctor's signature

Date 

D	D	M	M	Y	Y	Y	Y
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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 or third party/proxy signature on behalf of the member

Date 

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

ECOG Performance Status <sup>1</sup>	Karnofsky Performance Status <sup>2</sup>
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) <sup>2</sup>	Lansky Scale (recipient age > 1 year and < 16 years) <sup>3</sup>
<b>Able to carry on normal activity, no special care is needed</b> 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	<b>Able to carry on normal activity, no special care is needed</b> 100 — Fully active 90 — Minor restriction in physically strenuous play 80 — Restricted in strenuous play, tires more easily, otherwise active
<b>Unable to work, able to live at home, cares for most personal needs, a varying amount of assistance is needed</b> 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	<b>Mild to moderate restriction</b> 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
<b>Unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly</b> 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	<b>Moderate to severe restriction</b> 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.