## Advanced Illness Benefit & Compassionate Care Benefit application form

(To be completed by treating doctor)



Contact us

Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

## Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd (registration number 1997/013480/07), (referred to as 'the administrator') administers LA Health Medical Scheme. The administrator is a separate company and an authorised financial services provider.

## Purpose of the form

This form is to apply for palliative care through the Advanced Illness Benefit or the Compassionate Care Benefit.

## 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 2	
1. About the pati	ent
Title First name/s (as per identity document) Membership number Email	Initials Surname Date of birth Y Y Y M M D D
Residential address:	
Suite/Unit number	Complex name
Street number	Street name
Suburb	Postal code Postal code
2. About the pati	ent's next-of-kin
Title	Initials Surname Surname
First name/s (as per ident	ity document)
Relationship	
Email	
Cellphone	Telephone Telephone
Title	Initials Surname Surname
First name/s (as per ident	tity document)
Relationship	
Email	
Cellphone	Telephone Telephone

3. Advance Health	n Care planning	
	an Advance Care Plan and/or a Living Will? Yes No No nated third party's details or the proxy's details:	
Title	Initials Surname Surname	
First name/s (as per identified	ty document)	
Relationship		
Email		
Cellphone	Telephone Telephone	
4. About the refer	rring doctor	
Name and surname		
BHF practice number		
Speciality		
Telephone	Fax Fax	
Preferred method of co	ommunication	
Email		
Practice address		
	Code Code	
5. About the treat	ting doctor	
Same as above		
Name and surname		
BHF practice number		
Speciality		
Telephone	Fax Fax	
Preferred method of co	ommunication	
Email		
Practice address	Code Code	
6. Clinical summa	ry for patients with ADVANCED CANCER ONLY (treating doctor to complete)	
Date of assessment	2 0 Y Y M M D D	
Date of cancer diagnosi		
Main cancer diagnosis		
Current Stage TNM		
TX		
Describe other		
Metastasis Yes No Unknown		
Site of Metastasis Bone Brain Liver Lung Other (please specify)		
Previous chemotherapy, radiotherapy and surgical interventions		
Number of unplanned a	admissions in the past 6 months	
	ent discussed why you are applying for this benefit at this stage? Yes No	

6. Clinical summary for p	datients with ADVANCED CANC	LEK CINLY (treating doctor to com	olete) (continued)
Other relevant clinical information	on		
Treatment intent	Palliative Curative		
Disease directed treatment ongo	oing Yes No atment e.g. radiotherapy, chemothera	ny Dotaile	
ii <b>res</b> , provide the type of trea	——————————————————————————————————————	py. Details.	
If nalliative chamatherany plans	and provide details of exact intent of	treatment of tumour recognics im	provement in function, symptom control
(please specify). Details:	led, provide details of <b>exact intent</b> of t	treatment, e.g. tumour response, im	provement in function, symptom control
(picase specify). Details.			
Treatment start date	Y Y Y M M D D		
Planned duration of treatment			
If " <b>No</b> ", provide the date and de	etails of the last treatment		
Date	Y Y Y M M D D		
Details			
Details			
7. Clinical summary for p	patients with NON-ONCOLOGY	CONDITIONS ONLY (treating d	octor to complete)
Date of assessment	Y M M D D		
Date of diagnosis	Y M M D D	ICD-10 code	:
Main Diagnosis			
Number of unplanned admission	ns in the past 6 months		
Have you and your patient discu	ussed why you are applying for this be	nefit at this stage? Yes No No	
Treatment to date			
Other relevant clinical information	on including any functional classificati	on scoring system related to the cor	ndition e.g. NYHA and pathology results
8. Performance status (tr	reating doctor to complete for patien	ts ≥ 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>	

<sup>\*</sup>Refer to page 5 for more information

9. Performance status (	reating doctor to comple	te for patients	≤ 16 years)*				
Current Performance status*			Performance status 6 months ago*				
Lansky Scale <sup>3</sup>	ansky Scale <sup>3</sup>			Lansky Scale <sup>3</sup>			
*Refer to page 5 for more infor	mation	1			<u>'</u>	,	
10. Palliative care plan (	treating doctor to comple	ete)					
Medication							
Item	Dose	Frequency		Duration	R	epeat	
<u> </u>	<u> </u>						
Other supportive treatment							
Social Worker	Please specify: _						
Counselling							
Home Nursing (excluding frail care)	Please specify: _						
Oxygen	Please specify: _						
Hospice	Please specify: _						
Referral to palliative care do	ctor Please specify: _						
☐ Equipment	Please specify: _						
(subject to plan type and rev  ☐ Other	view) Please specify: _						
	Please specify: _						
Planned date of next assessmer	nt <b>2 0</b> Y Y M M D	D					
11. Other treating doctor	ors						
Name	Speciality		Phone	Email			
Name	Speciality		Phone	Email			
I understand what the Advance	d Illness Benefit can offer	to the patient a	nd that he/she	is comfortable to	proceed with	registration.	
Doctor's Signature					Date	2 0   Y   M   M   D   D	
By signing consent, I give permi I understand that as the patient healthcare providers to be cont	s's condition changes, othe						
Member/patient or third party proxy signature on behalf of the	e member				Date	2 0 7 7 M M D D	

ECOG Performance Status <sup>1</sup>	Karnofsky Performance Status <sup>2</sup>
0—Fully active, able to carry on all pre-disease performance without	100—Normal, no complaints, no evidence of disease
restriction	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,	80—Normal activity with effort, some signs or symptoms of disease
office work	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	40—Disabled, requires special care and assistance
than 50% of waking hours	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
to bed of criali	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>
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	100—Fully active
90—Able to carry on normal activity, minor signs or symptoms of disease	90—Minor restriction in physically strenuous play
20. Normal activity with affart come signs or symptoms of disasse	80—Restricted in strenuous play, tires more easily, otherwise active
80—Normal activity with effort, some signs or symptoms of disease	
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	70— Both greater restrictions of, and less time spent in active play
work 60—Requires occasional assistance but is able to care for most of	60— Ambulatory up to 50% of time, limited active play with assistance/ supervision
personal needs 50—Requires considerable assistance and frequent medical care	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	40— Able to initiate quiet activities
30—Severely disabled, hospitalisation is indicated, although death not imminent	30— Needs considerable assistance for quiet activity
20—Very ill, hospitalisation and active supportive care necessary	20— Limited to very passive activity initiated by others (e.g. TV)
	10— Completely disabled, not even passive play
10—Moribund, fatal process progressing rapidly	

- 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.