

**APPLICATION FORM**

TEL NO: 3184210

FAX NO: 3184230

(Office Hours 08:00 - 17:00, Monday - Friday)

P. O. Box 632, Fairgrounds, Gaborone

E-mail: bomaid@bomaid.co.bw



**A. PRINCIPAL MEMBER DETAILS - To be completed by the principal member**

Medical Scheme	<b>BOTSWANA MEDICAL AID SOCIETY</b>	Surname	
Scheme Option		Full Names	
Medical Aid No		Title	Mr Mrs Ms Dr Prof Other
Employer		Birth Date	D D M M Y Y Y Y
Tel. No (H)	0 9 2 6 7	ID Number	
Tel. No (W)	0 9 2 6 7	Alternative Tel. No	
Fax No	0 9 2 6 7	E-Mail Address	

**B. ADDRESS DETAILS - Please complete all three address areas**

<b>Address of nearest &amp; most convenient Post Office (1)</b>		<b>Postal Address (2)</b>	
Name		P O Box	
Suburb/ Ward		Suburb/ Ward	
City/ Village		City/ Village	
Postal Code		Postal Code	
<b>Work or Home Address (3)</b>			
Building No.		Building Name	
Street No.		Street Name	
		Suburb/ Ward	
		City/ Village	
		Postal Code	

**C. PATIENT DETAILS - Please provide details of the patient who requires the medication**

Dependant Code	Relationship	Name	Date of Birth	Contact Number	Sex
			D D M M Y Y Code		M F
			D D M M Y Y Code		M F
			D D M M Y Y Code		M F

I hereby give consent that this application for chronic medication be given to BOMAID to perform drug utilisation review (DUR) if this service is provided for the sole purpose of enhancing my medical benefit. I understand that BOMAID needs to access personal clinical information in order to make informed recommendations regarding my chronic medication. I therefore authorise any medical service provider in possession of any medical information regarding myself or any of my dependants to provide BOMAID sufficient information that they may require, excluding any information which I stipulate in writing to my medical service provider. I acknowledge that my medical service provider retains responsibility for my treatments and diagnosis.

I hereby certify that the information provided on this application form is correct and I understand the terms of this application. I also understand that my participation is subject to my eligibility under the Medical Society.

Generic medication can significantly reduce prescription costs, while providing similar medical effect. Should there be an equivalent available (after agreement with your Doctor) would you be prepared to use generic product?

Yes  No

Signature (Principal Member)

Date

**F. MEDICAL PRACTITIONER'S DETAILS - To be completed by the medical practitioner**

Medical Practitioner's name: Surname  Initials

If generic equivalent exists for products prescribed, may suitable generics be used for this patient? (Please indicate with an X)  Yes  No

Practice postal address

Code

Telephone number  Fax number

Speciality

Botswana practice number

E-mail Address

**G. CONDITION AND MEDICATION DETAILS - To be completed by attending medical practitioner (1 Form per patient)**

Patient Name: Initials  Surname  Title

Chronic conditions (Please Describe)	Medication prescribed (State strength, dosage & quantity)	Allergies	How long has the member been on this medication		How many repeat prescriptions would you like your patient to receive (months)					
			Years	Months	3	6	9	12	Other	
1.										
2.										
3.										
4.										

**H. CLINICAL INFORMATION - To be completed by medical practitioner**

**General**

Weight  Kg Height  cm

Blood Pressure  mmHg

Smoker Y  N  Ave per Day

Stress Level Mild  Moderate  Severe

Exercise Mild  Moderate  Severe

Please specify type of exercise: \_\_\_\_\_

Patient History	Description	Family History
Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Disease	Y <input type="checkbox"/> N <input type="checkbox"/>
Y <input type="checkbox"/> N <input type="checkbox"/>	Previous Myocardial Infarction	Y <input type="checkbox"/> N <input type="checkbox"/>
Y <input type="checkbox"/> N <input type="checkbox"/>	Other Major Ailments	Y <input type="checkbox"/> N <input type="checkbox"/>

Please Specify Ailments: \_\_\_\_\_

Signature of Medical Practitioner

/  / 20

Date Signed