

Personal Medical Assessment



Contact details
Tel: 0860 002 133 • www.sabmas.co.za

Who we are

SAB Medical Aid (referred to as 'the Scheme'), registration number 1209, is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd. registration number 1997/013480/07, (referred to as 'the Administrator') is a separate company and an authorised financial services provider and is responsible for the administration of your membership on behalf of the Scheme.

Principal member's name and surname	
Membership number	
Patient's name and surname	
Patient's date of birth	
Admission date	

How to complete this form

Please fill in the whole form and attach detailed supporting documents to avoid administrative delays.

Email the completed and signed form with any supporting documents to standards@sabmas.co.za

1. Diagnosis details

Initial treatment	ICD-10 code	RPL code
Diagnosis description		
Date of first diagnosis or onset of symptoms		
Date of your first consultation with the patient		

Has the patient consulted any other healthcare professional for this condition or these symptoms? If the answer is yes, please supply full details

Duration of symptoms	
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Brief history of main complaint

Other diagnoses	ICD-10 code	RPL code
Diagnosis description		

Has the patient consulted any other healthcare professional for this condition or these symptoms? If the answer is yes, please supply full details

2. Investigation details

Investigations	Date								Results
History of diabetes	D	D	M	M	Y	Y	Y	Y	
ECG (applies to cardiac conditions)	D	D	M	M	Y	Y	Y	Y	
Blood pressure (applies to cardiac conditions)	D	D	M	M	Y	Y	Y	Y	
Blood lipid level and current treatment (applies to cardiac conditions)	D	D	M	M	Y	Y	Y	Y	
Other	D	D	M	M	Y	Y	Y	Y	

Surgical history / hospitalisation / admission/s to any institution/s? Yes ☐ No ☐

Duration of stay		Reason or presenting symptoms on admission	Hospital or institution	Treatment details (including operations or procedures performed)	Final diagnosis (with results or any tests or investigations done)
From	To				

Date of consultation	Presenting symptoms and/or complaints	Duration of symptoms	Diagnosis (to include BP readings and laboratory test results)	Treatment given or prescribed

3. Other details about the patient

Weight

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 kg

Smoking habits (applies to cardiac and respiratory conditions)

4. Treatment details

Current treatment

Any extra information or previous treatment/s

Referring healthcare professional's name

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Referring healthcare professional's practice number

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(Where applicable, please include any referral forms)

Please attach any relevant reports to the completed form.

We require this information to assess the contractual requirements between the Scheme and your patient. This is not an assessment of clinical investigation or treatment.

5. Recent request for benefit/s

Please insert requested benefit codes below
(i.e. ICD-10 codes, procedure codes, etc.)

Description

6. Healthcare professional's details

Name and surname

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BHF practice number

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Speciality

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Telephone

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Email

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Healthcare professional's
signature

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Date

D	D	M	M	Y	Y	Y	Y
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