Filing Nr: Auth Nr:

SOUTH AFRICAN ONCOLOGY CONSORTIUM: ONCOLOGY MOTIVATION FORM

CMAC
Dr. Pikkie Kok
FINANCIAL & HEALTHCARE ADVISOR

1: PATIENT DETAILS

Surname: First Name: Initials:

ID Number: Date of First Diagnosis: Date of Birth:

Dependant Code: Telephone Number: Gender:

2: MEDICAL AID DETAILS

Principal Member Surname: Principal Member Initials: Membership Number:

Medical Aid: Benefit Option:

3: PRACTITIONER DETAILS (PRAC)

Surname: Initials: Practice Number:

Contact Person Surname: Contact Person Initials: Contact Person Name:

Telephone Number: Fax Number: HPCSA Number:

E-mail Address:

Practice Number to Receive E-Mail Authorisation:

4: PATIENT HISTORY

Primary Site: ICD Code:

Histology: Grade:

Performance Status - ECOG scale: Receptors:

Dates	Previous Treatment	Outcomes	Comments

Disease Stage: T: N: M: Other - Specify:

Metastases: ☐ Lung ☐ Brain ☐ Bone ☐ Liver Other - Specify:

Comorbid Diseases:

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5: CRITERIA FOR PMB CONDITION

Description of Condition: PMB Code:

☐ Spread to adjacent organ ☐ Irreversible/irreparable damage to organ of origin or other vital organ

☐ Evidence of distant, metastatic spread ☐ Demonstrated 5 year survival rate for this cancer is greater than 10%

6: TREATMENT INTENT and REVIEW

Plan Effective Date: Treatment Intent: Chemotherapy:

☐ Hormone Manipulation ☐ Radiotherapy Treatment Other Treatments - Specify:

SAOC Level: In / Out Patient:

Hospital Name: Hospital Practice Number:

Motivation for Hospitalisation:

Additional Comments:

Treatment Review:

Practitioner's Signature:_____ **Date:** _____

7: TREATMENT - RADIOTHERAPY (RAD)

Provider Name (Professional): Practice Number (Professional):

Provider Name (Technical): Practice Number (Technical):

Radiotherapy / Planning Start Date: Area of Interest:

	CODE(S)	QTY	PROF FEE	TECH FEE	TOTAL
Planning Code 1:					
Planning Code 2:					
Radiation Code 1:					
Radiation Code 2:					
Radiation Code 3:					
Brachy Code1:					
Brachy Code2:					
Brachy Code3:					
		Supporting Items Costs:		**Estimated Total Costs:**	

If no Technical fees are reflected in this section, please look out for a separate quote from a hospital provider.

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8: TREATMENT - CHEMOTHERAPY DRUGS (CHEM)

Provider Name (Professional): | Practice Number (Professional):

Provider Name (Facility): | Practice Number (Drugs):

Chemotherapy Starting Date: | Height: | Weight: | Body Surface:

Infusional Fee Code: | Infusional Fee Quantity: | Infusional Fee Amount:

Non Infusional Fee Code: | Non Infusional Fee Quantity: | Non Infusional Fee Amount:

Number of Cycles: | Supporting Items (Est): | Drugs (Est): | Estimated Cost per Cycle:

SAOC Equivalent Codes: | Port ☐ | Total Estimated Cost:

DRUG	NAPPI	ROUTE	QTY	FREQUENCY	COST PER CYCLE

9: TREATMENT - SUPPORTING DRUGS / ISOTOPES / MATERIALS

DRUG / ISOTOPES / MATERIALS / FLUIDS	NAPPI	PROV	ROUTE	QTY	FREQUENCY	COST PER CYCLE
Material Estimate	See Account					

Practitioner Support Total | **Rad Support Total** | **Chemo Support Total**