Private Bag X82081, Rustenburg, 0300 • Tel: 014 590 1700 • Fax: 086 577 0274 • www.platinumhealth.co.za
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PLATCOMPREHENSIVE/PLATCAP
CLINICAL MOTIVATION FORM
MEDICINE OUTSIDE FORMULARY

1. Please complete the clinical motivation form in PRINT with black ink and forward to Platinum Health.
2. Relevant test results must be attached.
3. Prescription must be attached.
4. Failure to provide all information, will result in unnecessary delays.

1 PATIENT DETAILS (Please complete in full)

Platinum Health membership number: ______ Patient dependant code: ______

Title: Prof | Dr | Mr | Ms Initials: ______ Surname: ______

Names in full (as per identity document): ______

Date of birth: C C Y Y M M D D E-mail: ______

Tel no (Home): ______ Tel no (Work): ______ Cell no: ______

Signature: ______ (If the patient is a minor, parent, legal guardian or custodian must sign the form.)

2 PRESCRIBER'S DETAILS (Please complete in full)

Prescriber's name: ______

Prescriber's BHF: ______ Tel no: ______

Prescriber's speciality: ______

Signature: ______

Date: C C Y Y M M D D

3 MEDICAL DETAILS (Prescribing doctor to complete in full)

Condition(s) to be authorised:

Patient co-morbidities:

	PRODUCT NAME	STRENGTH	FORM	QUANTITY PER MONTH	START DATE	DURATION OF TREATMENT (MAX ONE YEAR) AND TERMINATION DATE	COST PER MONTH (SEP)	SCHEME TO COMPLETE	
								ACCEPTED/ REJECTED	WHICH BENEFIT? PMB/ CHRONIC/EX GRATIA
1									
2									
3									
4									
5									
6									
7									

Motivation from prescribing doctor:

(Please attach the relevant test results.)

Previous medication used:

Relevant test results must be attached hereto:

(Please attach the relevant prescription.)