President : Dr Chris Gouws / **Secretary** : Dr Rian Viljoen / **Treasurer** : Dr Jaco Maartens

Email: savrssecretary@gmail.com Fax 0866 188 640

APPLICATION FOR REIMBURSEMENT OF AN INTRAVITREAL INJECTION

Options:		
	Avastin	
	Lucentis	
	Eylea	
	Intravitreal dexametazone eg. Ozurdex	
	Triamcinolone	

	Patient details		**Principal member**
Title		**Title**	
Name		**Name**	
Surname		**Surname**	
ID Number		**ID Number**	
Age		**Medical Scheme Name**	
DOB		**Plan type / Option**	
Tel No		**Medical Aid Number**	
Treatment for Injection			
NAPPI CODE			
Chronic treatment for 2017			
Date of injection			
Right Eye	**Left Eye**	**Bilateral Eyes**	

PLEASE ATTACH A PRESCRIPTION THAT INCLUDES AN ICD 10 CODE

WE SUGGEST THAT THE PATIENT APPLIES TO THE MEDICAL AID FOR CHRONIC COVER OF THEIR PMB CONDITION

Date: _____

Doctor: _____ **Signature:** _____

Practice Number : _____

Doctor's Tel: _____ **Fax No:** _____

E-mail: _____ **Contact person:** _____

Delivery address: _____

_____

DIAGNOSIS

wAMD	H35.3	☐
CRVO / BRVO	H34.9 H34.8	☐
Diabetic macular oedema	E10.3, E11.3, H36.0, H35.8	☐
Other eg. myopia, uveitis, Birdshot, Radiation retinopathy	Code	Motivation:

CLINICAL HISTORY

Is the patient currently on treatment?

No ☐

New diagnosis ☐

Access to OCT ☐

Fluorescein angiogram Yes ☐ No ☐

Result if done

Phase of treatment: Initiation - loading doses
Yes ☐ No ☐

Yes - Maintenance regime ☐

Maintenance regime: Planned schedule of injections
Treat and extend: Yes ☐ No ☐

If Yes: Frequency of injections at present:
If No: Monthly ongoing
Please motivate _____

or
If prn: Please motivate _____

If changing treatment:

Indication for change:

Complications / adverse event	☐	
Non-responder	☐	Reason: _____
Suboptimal response	☐	Reason: _____