

Application for Registration on the Pick n Pay Mental Wellness Programme

Membership Number

Date

Surname

First Name/s

Is this registration for yourself or a family member?

Myself Family Both **Please complete a separate form for each person in your family if applicable**

Please specify your condition:

When were you diagnosed?

Do you take chronic medicines?

Y

N

Please provide us with your contact details in the spaces below so that we can keep in touch

Home Phone

code

Work Phone

code

ext

Shop/Department

Cell Phone (yours)

Cell Phone (alt)

e-mail Address

Postal Address

Where we can send you
information

Doctor's Name & Phone Number

N.B. In order to register you on the programme and/or consider chronic medication benefits, we need your doctor to confirm your diagnosis and complete a treatment plan document that includes the DSM IV (Diagnostic and Statistical Manual of Mental Disorders™) multiaxial assessment system criteria together with your latest prescription and treatment history.

May we contact your doctor directly for information?

Yes No

Please sign here:

ALL THE INFORMATION YOU GIVE US WILL BE KEPT STRICTLY CONFIDENTIAL AND WILL NOT BE SHARED WITH YOUR EMPLOYER OR ANYONE OTHER THAN YOUR DOCTORS AND PHARMACY WITHOUT YOUR PERMISSION.

Please return this form to the Pick n Pay Mental Wellness Programme:**By e-mail – pnpwell@pha.co.za or****Fax: 031 267 0227**

You can also contact one of our Nurses on the following number:
0860 767 633 – Option 4 from 08h00 to 16h30 Monday to Friday