Pick n Pay Medical scheme

pha PRIVATE HEALTH ADMINISTRATORS

Confirmation of Diagnosis and Treatment Plan

Complete form and e-mail to pnpwell@pha.co.za or fax to 086 539 1765

Patient		**Date of Birth**	
Medical Aid Number		**Dependant Code**	
Date Treatment Commenced		**Date of anticipated completion**	
Doctor Name		**Dr Practice no.**	
Doctor Telephone		**Doctor Fax**	

Indication for Therapy - Main Symptoms:

DSM IV Diagnosis	
Axis 1	
Axis 2	
Axis 3	
Axis 4	
Axis 5	**Current:** **Previous Year:**

Previous Psychiatric Treatment: If YES, Previous Diagnosis:

Previous Treatment:	**Compliance:**
Substance Abuse: YES / NO	**Type of Substance/s:**
Estimated length of dependence:	**Previous**
	Present

Treatment Plan					
Psychiatrist (name):			**Psychologist(name)**		
ECT treatment inpatient			**ECT treatment outpatient**		
Occupational Therapy:	**Yes**	**No**	**Group Therapy:**	**Yes**	**No**
Psychiatric Hospitalisation if any:					
Themes to be addressed during Therapy:					

Compliance:

Medications	Dosage	Frequency	Route

Estimated length of treatment and frequency – with reasons:

Discharge/Completion/Resolution Planning: Follow-up arrangements:

Doctor's Signature:		**Date:**	