Hollard.

DIABETIC QUESTIONNAIRE

(To be completed by the medical attendant)

Please return this completed form to ds_uwrequirements@hollard.co.za.

1. Life insured's details

Policy no. _____ Identity no. _____

Name of insured _____

1.1 When was diabetes first diagnosed? D D M M Y Y Y Y

1.2 Current height _____

1.3 Current weight _____

1.4 Has the patient's weight:

Reduced since diagnosis? YES ☐ NO ☐ _____

Increased since diagnosis? YES ☐ NO ☐ _____

1.5 Is the patient taking insulin? YES ☐ NO ☐

If YES, state the type of insulin and units per day _____

1.6 Is the patient taking oral treatment? YES ☐ NO ☐

If YES, state which type of drug and dosage _____

1.7 Has the patient's intake of insulin or oral drugs varied during the last 2 years? YES ☐ NO ☐

If YES, give details of previous dosage _____

1.8 Since treatment began, has the patient ever been in a diabetic or insulin coma? YES ☐ NO ☐

If YES, state number of events and dates _____

_____

_____

1.9 Provide result of:

HbA1c _____ SCR _____

Micro-albumin _____ CRP _____

HDL _____ Fasting triglycerides _____

1.10 a. How long has the patient been under your care? _____

b. Does the patient follow medical advice? YES ☐ NO ☐

c. How often does the patient have medical check-ups? _____

Supply date of last check-up D D M M Y Y Y Y

1.11 Has an electrocardiographic examination ever been carried out? YES ☐ NO ☐

If YES, state date of most recent examination and result D D M M Y Y Y Y

_____

_____

Initials (life insured) _____

1.12 Are there any diabetic complications present? YES ☐ NO ☐

If YES, state complications and date of diagnosis D D M M Y Y Y Y

1.13 Has the patient ever been referred to a specialist? YES ☐ NO ☐

If YES, provide the name of the specialist, dates of consultation and results

1.14 Is the patient on treatment for:

Hypertension? YES ☐ NO ☐

If YES, state date of examination and reading D D M M Y Y Y Y

Hypercholesterolaemia? YES ☐ NO ☐

If YES, state date of examination and reading D D M M Y Y Y Y

1.15 Is the patient on any other chronic medication, e.g. aspirin? YES ☐ NO ☐

If YES, state medication

2. Notice to medical attendants

Hollard Life will reimburse all medical accounts issued according to the insurance billing code A1403.

Full name

Qualifications Practice no.

Work tel. no. Cell no.

Email address

Postal address

Please send your account to ds_doctoraccount@hollard.co.za.

3. Declaration by medical attendant

I declare that the statements above are true and complete.

Signature (medical attendant) **Date** D D M M Y Y Y Y

Hollard Declaration

We respect and adhere to patient confidentiality and data privacy principles in relation to Personal Information. We will therefore only process this information for the purpose for which it is intended.