sa military health service

Department:
Defence
REPUBLIC OF SOUTH AFRICA

SOUTH AFRICAN MILITARY HEALTH SERVICE (SAMHS): PATIENT CLINICAL MOTIVATION FORM FOR MEDICINE NOT INCLUDED IN THE SAMHS MEDICINE FORMULARY

1. After completion of this clinical motivation form, please submit it to the SAMHS Medicine Formulary (SAMHS MF) Committee. Reference to supporting evidence, e.g. trials, studies, research papers and/or professional body guidelines must be attached. It is important that the motivation indicates why pharmaceuticals available are not acceptable.

2. Relevant test results, **a DD3638 or private prescription** and the SAHPRA Adverse Drug Reaction/Product Quality Problem Report Form, if applicable, must be attached. For non SAMHS prescribers, the referring SAMHS HCP must be indicated. As per the National Treasury Regulations, pharmaceutical trade names cannot be requested.

1 PATIENT'S DETAILS (Please complete in full or place patient's sticker)

Force Number										

Initials & Surname				
Gender	M	F	Date of Birth	
Contact Details: Telephone/email				

2 PRESCRIBER'S DETAILS (Please complete in full)

Prescriber's name				
Specialist Prescriber?	Yes	No	Specialist Discipline	

Signature	C	C	Y	Y	M	M	D	D	
Tel No									

3 MEDICAL DETAILS (Prescribing Specialist/Consultant to complete in full)

Medicine (generic name) to be authorised	
Duration of treatment	
Patient co-morbidities	

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Previous medicine used

	PRODUCT NAME	QUANTITY USED PER MONTH	START DATE	DURATION OF TREATMENT	TREATMENT OUTCOME
1					
2					
3					

Motivation from the prescribing doctor (Please indicate if the medicine motivated for is aligned with accepted and published professional guidelines, eg Hypertension Society of South Africa, National Osteoporosis Foundation.) Add pages and list relevant tests if necessary.

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4 **FOR SAMHS USE ONLY** (To be completed by SAMHS MF Committee)

Comments and recommendations

Is the motivated for medicine on proprietary contract?	Y	N	or quotation?	Y	N	
Is the motivation aligned with the SAMHS Medicine Formulary (SAMHS MF)?	Y	N				
Is the motivation aligned with best practise (Professional body guidelines)?	Y	N				
Cost per month=	R					
Was the Adverse Drug Reaction/Product Quality Problem Report Form included?	Y	N				
Refer back to prescriber?	Y	N				
to Director Medicine/HOD Clinical Speciality/Pharmacologist?	Y	N				
Approved?	Y	N				
Did you communicate the approximate supply time to: The prescriber?	Y	N	Patient?	Y	N	

Force Number Rank Name					Tel No			
Signature	C	C	Y	Y	M	M	D	D

SAHPRA
SOUTH AFRICAN HEALTH PRODUCTS REGULATORY AUTHORITY

ADVERSE DRUG REACTION (ADR)/PRODUCT QUALITY PROBLEM REPORT FORM
(PUBLIC AND PRIVATE SECTOR) (Including Herbal Products)

Reporting Health Care Facility/Practice					
Tel: 012 842 7609/10 (SAHPRA) 021 447 1618 (NADEMC) **Fax:** 021 448 6181 **E-mail:** adr@sahpra.org.za	Facility/Practice				
	District		Tel		
	Province		Fax		

Patient Details									
Force/ID Number		Initials & Surname			Date of Birth/Age				
Sex	□ M □ F □ Unk	Race		Weight (kg)		Height (cm)		Pregnant?	□ N □ Y
Allergies				Estimated Gestational Age at time of reaction					

Suspect Medicine(s) [Medicines suspected to have caused the ADR]

Trade Name [Generic Name if Trade Name is unknown]	Route	Dose (mg) and Interval	Date Started/Given	Date Stopped	Reason for use	Batch Number	Expiry Date

All other Medicines Patient was taking at time of reaction [Including over-the-counter and herbal products]

Trade Name [Generic Name if Trade Name is unknown]	Route	Dose (mg) and Interval	Date Started/Given	Date Stopped	Reason for use	Batch Number	Expiry Date

Adverse Drug Reaction/Product Quality Problem			
Date and time of onset of reaction		Date reaction resolved/duration	

Please describe Adverse Reaction/Product Quality Problem: (kindly add as much clinical information as possible)

Intervention(tick all that apply)	**Patient Outcomes (tick all that apply)**
□ No intervention □ Intervention unknown □ Patient counselled/non-medical treatment □ Discontinued Suspect Drug. **Replaced with:** _____ □ Decreased Suspect Drug Dosage. **New Dose:** _____ □ Treated ADR - with: _____ □ Referred to hospital. **Hospital Name:** _____ □ Other intervention (e.g. dialysis): _____	□ ADR recovered/resolved □ Recovering/resolving □ Not recovered/not resolved □ Life threatening □ Impairment/disability □ Congenital anomaly □ Patient hospitalised or hospitalisation prolonged □ Patient died: Date of death: _____ □ Other: _____ □ ADR reappeared after restarting suspect drug/similar drug (rechallenge)?: □ N □ Y □ Not done □ Unknown

Laboratory Results			**Additional Laboratory Results**		
Lab Test	**Test Result**	**Test Date**	**Lab Test**	**Test Result**	**Test Date**

Co-morbidities/Other Medical Condition(s)

Reported by			
Name		E-mail	
Designation	□ Nurse □ Pharmacist □ Doctor □ Other:	Telephone	
Date reported		Signature	

THIS ADR REPORT IS NOT A CONFIRMATION THAT THE REPORTER OR THE SUSPECT MEDICINE(S) CAUSED THE ADR **V5.0 05/19**

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CONSULTANT'S RESTRICTED MEDICINE FOLLOW UP AUTHORITY[1] SG0006	
A PATIENT INFORMATION	**Place of service**
No.....: _____ Rank/Title _____ Inits & surname: _____ Gender.....: _____ (F/M) DOB.: _____ Admin unit.....: _____ Contact tel.....: _____ Cons no.....: _____	Institute.....: _____ Location.....: _____ Service point: _____ Discipline.....: _____

B CONSULTATION PARTICULARS			
Consultation date		**Consultation time**	
Laymans diagnosis (with consent of patient)			
Allergies			

C CONSULTANT'S FOLLOW-UP RECOMMENDATIONS	
Medicine	**Dose**
Date of next visit to consultant	
Special Instructions	

D Notes to Patient	HCP Information
This authority form is not a prescription, but an authority for a Medical Officer to prescribe restricted medication started by a consultant. Hand this form to the Medical Officer you are seeing at your Home Unit. This follow-up form is valid for *1 year only*. Ensure that you keep a copy of this authority form. Ask the pharmacist to return the form to you after your medication has been dispensed.	HCP no.....: _____ Inits & surname : _____ HCP discipline..: _____ Duration of cons: _____ min | Tel.: _____ Signature.....: _____ Qualification.....: _____

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[1] Military Medical Code List (MMCL)