health
Department:
Health
REPUBLIC OF SOUTH AFRICA

MEDICINE REFERRAL PRESCRIPTION FOR THE CCMDD PROGRAMME

Rx No: 20230601

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

SURNAME:	**NAME:**	**ALLERGIES:**		**Clinic/CHC/Hospital Name**
		GENDER:	**DOB:**	CLINIC / HOSPITAL STAMP
		LANGUAGE:	**AGE:**	
PATIENT'S ADDRESS:		**ID NUMBER or PASSPORT NUMBER:**		**Clinical Review Only** ☐ *If clinical review option is selected* *NO medication will be dispensed by Dispensary* *Clinical review date need to be during month 5*
		FILE NUMBER:		
		LANGUAGE:		**Next Clinical Visit Date/Time**
FIX PATIENT STICKER HERE		**CELLULAR NUMBERS:**		New Patient ☐ Repeat Patient ☐

Date

Diagnosis (as per approved list by District PTC)

- ☐ Allergic Rhitis
- ☐ Angina Pectoris Stable
- ☐ Asma / COPD
- ☐ Benign Prostatic Hyperplasia
- ☐ Breast Cancer (Adjuvantant Metastatic)
- ☐ Cardiac Fialure, Congestive
- ☐ Chronic Canvcer Pain
- ☐ Chronic Non Cancer Pain
- ☐ Conjuctivitis, Allergic
- ☐ Diabetes Mellitus, Type 2
- ☐ Diabetic Neuropathy
- ☐ Dry eye
- ☐ Epilepsy
- ☐ Family Planning
- ☐ Glaucoma
- ☐ HIV
- ☐ Hormone Replaement Therapy
- ☐ Hyperlipidaemia
- ☐ Hypertenstion
- ☐ Hypothyroidism
- ☐ INH Prevantative Therapy
- ☐ Neuropathy
- ☐ Osteo Arthritis
- ☐ Overactive bladder
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ STEMI
- ☐ Uveitis
- ☐ Other:

- ☐ Mental Health – state diagnosis

Diagnosis in italics – Only for Hospitals

SELECTED PICK-UP POINT
(select from options provided by CCMDD Task Team)

NOMINATED PERSON TO COLLECT MEDICINE ON BEHALF OF PATIENT

Name:

ID Number:

Tel no:

Next Collection Date(s):

PRESCRIPTION FOR ONE TIME USE ONLY

	DETAILS OF PRESCRIPTION (Use only generic names and official abbreviations)	First Issue Details
1	or equivalent	Date / Quantity / Batch No / Disp Sign
2	or equivalent	Date / Quantity / Batch No / Disp Sign
3	or equivalent	Date / Quantity / Batch No / Disp Sign
4	or equivalent	Date / Quantity / Batch No / Disp Sign
5	or equivalent	Date / Quantity / Batch No / Disp Sign
6	or equivalent	Date / Quantity / Batch No / Disp Sign
7	or equivalent	Date / Quantity / Batch No / Disp Sign
8	or equivalent	Date / Quantity / Batch No / Disp Sign
9	or equivalent	Date / Quantity / Batch No / Disp Sign
10	or equivalent	Date / Quantity / Batch No / Disp Sign

Prescriber Stamp / Name and Designation		**Signature**	*Prescriptions may be prescribed for 28/56/84 days*
Prescriber contact number		**HPCSA/SANC No**	
For Pharmacy Use	**PATIENT COUNSELLED on correct usage of medication and PUP selection (Mandatory field)**		
	Signature	Date	

Number of Repeats

- 28 Days = 5 Repeats ☐
- 56 Days = 4 Repeats ☐
- 84 Days = 3 Repeats ☐

PATIENT CONSENT (Mandatory field)
I agree to participate in the programme for alternative distribution ad pick-up of my chronic medication.

Patient Signature	Date	Facility Signature	Date

CCMDD Service Provider Processed Rx	**TIER.Net capturing**	**CCMDD stats captured**
Date and Signature	**Date and Signature**	**Date and Signature**

September 2023 Gauteng