ORIGINAL DATE: 27/08/2021	**PSMAS QMS** **CHRONIC DISEASE REGISTRATION FORM**	PSMAS PREMIER SERVICE MEDICAL AID SOCIETY Committed to Care Procedure No. PSMAS QMS PHW19 Page 1 of 1
REVISED DATE: 27/08/2021		
REVISION No: 0		

Upon completion, kindly submit this form at any PSMAS branch or via e-mail on diabetescare@psmas.co.zw or premierlifestyle@psmas.co.zw

Member's Name		***Date of Registration***	
Patient's Name		***Membership No. & Suffix***	
National ID No.		***Date of Birth***	
Gender		***E-mail address***	
Patient Contact (Voice Calls)		***Patient Contact (WhatsApp)***	
Physical Address			

Chronic condition code	**Year of Drug commencement**	**Medication and strength of drugs being taken**	**Attending Doctor for Your condition**

Chronic conditions codes

1)Hypertension	2)Diabetes	3)Psychiatric conditions	4)Asthma	5)Cancer,Specify type_____
6)HIV	7)Cardiovascular Problems		8)Renal Disease	9)Other,Specify_____
			Are you on dialysis? Yes No	
			If Yes,Specify no. of cycles per week:	

Name of nearest Hospital/Clinic……

Patient`s consent

I confirm that the information contained on this form is correct. **Signature**: ……**Date**: ……

NB: By completing the soft copy, member agrees to the terms of the program.