

Alignd Serious Illness Benefit (SIB) Enrolment Form

Have you & your patient discussed why you are applying for SIB at this stage?

Yes No

Referring Doctor Name	
Date (DD/MM/YYYY)	

1. Patient information

Patient Full Name	
Date of birth (DD/MM/YYYY)	
Age	
ID Number	
Medical Aid	
Medical Aid Number	
Dependant number	
Contact number	
Next of kin contact name	
Next of kin contact number	
Address	

2. Clinical summary

Date last seen	
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Primary cancer diagnosis												
ICD-10 Code												
Date of first diagnosis												
Date of first palliative care consult, if applicable												
Current stage TNM	TX		T0		T1		T2		T3		T4	
	NX		N0		N1		N2		N3			
	MX		M0		M1							
If other, please describe												
Site of metastasis (if applicable)												

3. Performance status

Please use the **ECOG Performance Scale** (OR **Lansky Performance Scale** if patient is under 16 years).

ECOG

Current performance status	0		1		2		3		4	
Performance status 6 months ago	0		1		2		3		4	

LANSKY (only needed if patient is under 16 years)

Current performance status	10	20	30	40	50	60	70
			80	90	100		
Performance status 6 months ago	10	20	30	40	50	60	70
			80	90	100		

4. Doctor's signature



The above information is true and correct, and the patient or identified next-of-kin has consented to proceed with enrolment onto the Alignd benefit.

Signature	
Name and Surname	