CAMAF
MEDICAL SCHEME
IN A CLASS OF ITS OWN

CAMAF PSYCHOTHERAPY TREATMENT PLAN

(FOR DOCTOR / THERAPIST TO COMPLETE)

Date: _____

Return to e-mail: **emotional.wellness@camaf.co.za** or fax **011 707 8747**

Patient's name: _____

Membership number: _____

Patient's contact number: _____

Patient's e-mail: _____

KINDLY INDICATE BELOW, THE DETAILS OF THE PROPOSED TREATMENT: DSM V

ICD 10 Code: _____

Diagnosis / disorder	
Problem definition / severity	
Strengths / weakness	
Goals from counselling	

MANAGEMENT AND TREATMENT

Method of management: _____

Start date: _____ End date: _____

Number of sessions required: _____

Previous history: _____

Current medication / dosage: _____

_____

PLEASE INDICATE PRACTICE TYPE

Psychiatrist	
General Practitioner	
Clinical Psychologist	
Industrial Psychologist	
Educational Psychologist	
Counselling Psychologist	
Clinical Social Worker	
Other (specify)	

Doctor / Therapist name:	
Practice number:	
HPCSA Registration No:	
Telephone number:	
Fax:	
E-mail address:	

Signature: _____