POLMED®
OUR INVESTMENT OUR HEALTH OUR FUTURE

HIV Application Form
Confidential
v2.0.1

The HIV programme does not dispense medication - Please fax this completed form to 0800 600 773 or email it to polmedhiv@medscheme.co.za

This SECTION needs to be completed by - THE APPLICANT | Applications will be rejected unless signed by both Applicant and Doctor

Principal (Main) Member Details

First Name _____ Surname _____

Medical Scheme _____ Gender Male Female

Membership No. _____ Option/Plan _____

Patient Details

First Name _____ Surname _____

Dependent Code _____ Gender Male Female

ID Number _____ Date of birth D D M M Y Y Y Y

Treatment Support is a vital part of the HIV programme. Contact details must be supplied to enable us to provide you with this support.

Confidential Email _____

Postal Address for Confidential Mail _____

Postal Code _____ Telephone (Work) _____

Fax _____ Telephone (Home) _____

Preferred form of Communication Email Fax Post

Cellphone _____

First Language _____

What time of Day do you wish to be Contacted Morning Afternoon

Second Language _____

Next of kin or trusted friend who can be contacted if we cannot reach you **(should know your HIV status)**

First Name _____ Telephone (Home) _____

Surname _____ Telephone (Work) _____

Cellphone _____

I understand that all personal clinical information supplied to the HIV programme will be used to determine access to specific benefits for people with HIV infection. HIV programme will take all reasonable steps to maintain confidentiality. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. Your doctor, however, retains responsibility for your care, irrespective of the benefits so authorised. I/we therefore, authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependant (also newly born baby), to provide the HIV programme with information that it may require. I warrant that the information in this application form is correct. I acknowledge that completion of the application form does not automatically entitle me to any benefits and that acceptance to the programme is within the sole discretion of the HIV programme. I acknowledge that I am familiar with the conditions and benefits of the programme, notwithstanding representation by any other party; and agree to abide by and undertake to familiarize myself with the rules of the programme as amended from time to time. I acknowledge that benefits authorised by the HIV programme are subject to scheme rules and that non adherence to the programme could result in my benefits from this programme being cancelled. I acknowledge that I will be responsible for any co-payments as per scheme rules or payment for any medication and/or investigations not authorised by the HIV programme. I understand that acceptance onto the HIV programme means that an HIV treatment support counsellor will contact me. I herewith authorise the HIV programme and its agents/medical staff to disclose the medical information relevant to my HIV infection to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

Patient's signature _____ Date D D M M Y Y Y Y

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This SECTION needs to be completed by - THE DOCTOR

Doctor Details

Surname & Initials _____ Practice No. _____

Email Address _____ Telephone _____

Postal Address _____

Postal Code _____ Cellphone _____

Preferred form of Communication [Email] [Fax] [Post] Fax _____

Clinical History

When was HIV infection first diagnosed? (Please attach reports)

Type of Screening Test _____ Test Date D D M M Y Y Y Y

Type of Confirmatory Test _____ Test Date D D M M Y Y Y Y

Is the patient currently being treated for Tuberculosis? [YES] [NO] If YES, specify start date D D M M Y Y Y Y

Has the patient previously been exposed to antiretrovirals? [YES - MTCT prophylaxis] [YES - Other] [NO]

If YES, please provide details - Note: If the application is for a baby please list mom's previous ART history.

Drugs	Start Date	End Date	Duration (Months)	Reason for Discontinuation

Current combination patient is taking _____ Start Date D D M M Y Y Y Y

Please list all other medication the patient is taking, including prophylaxis _____

Is the patient allergic to any medication? Sulphonamides [YES] [NO] Other Allergies [YES] [NO] If YES, specify _____

Information required to prevent adverse side-effects of certain drugs

Current heavy alcohol intake? (i.e. more than 4 drinks per day for a long period of time) [YES] [NO]

Current recreational drug use? (Cannabis, Cocaine, Ecstasy, LSD etc.) [YES] [NO]

Current depression or psychiatric illness? [YES] [NO]

If YES, specify treatment _____

Current use of traditional or herbal remedies? [YES] [NO]

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Clinical Examination

Weight ____ kg
Height ____ cm

WHO Clinical Staging 1 2 3 4

Please tick disease below if Stage 3 or 4

Pregnant YES NO
If YES, specify
Expected date of delivery D D M M Y Y Y Y
Expected mode of delivery NVD C/S
Expected date of C/S D D M M Y Y Y Y

Clinical Stage 3 - Adult / Adolescent

Unexplained severe weight loss (>10% of body weight)	
Unexplained chronic diarrhoea > one month	
Unexplained persistent fever > one month	
Persistent oral candidiasis	
Oral hairy leukoplakia	
Pulmonary tuberculosis	
Severe bacterial infections (e.g. pneumonia)	
Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis	
Unexplained anaemia, neutropaenia, chronic thrombocytopaenia	

Clinical Stage 3 - Paediatric

Unexplained moderate malnutrition	
Unexplained persistent diarrhoea (14 days or more)	
Unexplained persistent fever > one month	
Persistent oral candidiasis (after first 6 weeks of life)	
Oral hairy leukoplakia	
Acute necrotizing ulcerative gingivitis / periodontitis	
Lymph node TB	
Pulmonary TB	
Severe recurrent bacterial pneumonia	
Symptomatic lymphoid interstitial pneumonitis	
Chronic HIV-associated lung disease including bronchiectasis	
Unexplained anaemia,neutropaenia,chronic thrombocytopenia	

Clinical Stage 4 - Adult / Adolescent / Paediatric

HIV wasting syndrome (See Clinical Guidelines for definitions)	
Pneumocystis pneumonia	
Recurrent severe bacterial pneumonia	
Chronic herpes simplex infection	
Oesophageal candidiasis	
Extrapulmonary tuberculosis	
Kaposi's sarcoma	
Cytomegalovirus infection (retinitis or infection of other organs)	
Central nervous system toxoplasmosis	
HIV encephalopathy	
Extrapulmonary cryptococcosis including meningitis	
Disseminated non-tuberculous mycobacterial infection	
Progressive multifocal leukoencephalopathy	
Chronic cryptosporidiosis	
Chronic isosporiasis	
Disseminated mycosis	
Recurrent septicaemia (including non-typhoidal Salmonella)	
Lymphoma (cerebral or B-cell non-Hodgkin)	
Invasive cervical carcinoma	
Atypical disseminated leishmaniasis	
Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy	

Is there any degree of peripheral neuropathy? YES NO
Is there any degree of peripheral neuropathy? Mild Moderate Severe
Is there any other significant clinical finding? YES NO
If YES, please specify _____

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Special Investigation Results (Please provide copies of reports. Supply as many results as possible, including baseline results)

Date Test Performed (D D M M Y Y Y Y)	CD4 count (cells / mm)	CD4% (must be provided for children)	Viral Load (copies / ml)

Additional Investigations	Test Done	If YES, specify results	Test Date
Blood count(s) (Essential prior to approval of Zidovudine)	YES NO		D D M M Y Y Y Y
Baseline ALT (Essential prior to approval of Nevirapine)	YES NO		D D M M Y Y Y Y
Serum creatinine/eGFR (Essential for patients with renal failure or prior to approval of Tenofovir	YES NO		D D M M Y Y Y Y

Medication (Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated)

Antiretrovial Therapy	Strength (e.g. 10 mg)	Directions (e.g. 1 tds)	Period in Use (months)	Period Required (months)

Other Medication Required (Associated with the management of HIV)

Diagnosis	Medicines	Strength (e.g. 10 mg)	Directions (e.g. 1 tds)	Period in Use (months)	Period Required (months)

Acknowledgement by Examining Doctor

Please Note:

- Tariff code 0199 will only be paid for the first time completion of the application form. The form must be completed in full and signed by both the patient and the doctor.
- Approval for ongoing antiretroviral therapy will only be considered if the result and date of a recent CD4 count and viral load is supplied. Only medication recommended in the HIV Clinical Guidelines will be considered for reimbursement. Please refer to these guidelines or contact the HIV programme on 0800 22 7700, or at polmedhiv@medscheme.co.za for further information. Motivations will however always be considered. Please contact the HIV programme for assistance if required.

I certify that the above particulars are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and procured the tests and/or other diagnostic investigations referred to. I confirm that I have counselled the patient on the importance of adhering to medication and monitoring test regimens. I acknowledge that the HIV programme will rely on such particulars when making any recommendations regarding payment for treatment to the relevant medical scheme. I acknowledge that telephonic discussions will be taped for medico-legal purposes.

Doctor's signature _____ Date D D M M Y Y Y Y

Medical Aid Number	Dep Code	Patient Name	