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Post-Exposure Prophylaxis (PEP) Application Form Confidential

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

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 ____________________

Doctor Details

Surname & Initials ____________________ Practice No. ____________________

Email Address ____________________ Telephone ____________________

Postal Address ____________________

Postal Code ____________________ Cellphone ____________________

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

Details of HIV Exposure (i.e rape/needle stick injury)

Nature of Incident ____________________ Has Post-Exposure Treatment been started? [YES] [NO]

Date of Incident [D][D][M][M][Y][Y][Y][Y] If YES, when? ____________________

Time of Incident ____________________ Details (e.g. starter pack) ____________________

Details of Source Patient/Perpetrator (e.g. HIV Status) ____________________

Has a Baseline HIV test been done on the patient? [YES] [NO] Baseline HIV Result ____________________

Medication - Note: Medication will be authorised for one month where indicated. Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated	**Dose - For Child, please supply : Height =** **Weight =**

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. The 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 ofmy identity.

Patient's signature ____________________ Date [D][D][M][M][Y][Y][Y][Y]

Doctor's signature ____________________