

Pre-Exposure Prophylaxis (PrEP) Application Form Confidential



POLMED

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AfA does not dispense medication - Please email this completed form to polmedhiv@medscheme.co.za
Applications will be rejected unless signed by both Applicant and Healthcare Provider

Principal (Main) Member Details

First Name	<input type="text"/>	Surname	<input type="text"/>
Medical Scheme	<input type="text"/>	Gender	<input type="button" value="Male"/> <input type="button" value="Female"/>
Membership No.	<input type="text"/>	Option / Plan	<input type="text"/>

Patient Details

First Name	<input type="text"/>	Surname	<input type="text"/>
Dependant Code	<input type="text"/>	Gender	<input type="button" value="Male"/> <input type="button" value="Female"/>
ID Number	<input type="text"/>	Date of Birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

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

Confidential Email	<input type="text"/>	Telephone (Home)	<input type="text"/>
Preferred form of communication	<input type="button" value="Email"/> <input type="button" value="Print to SMS"/>	Telephone (Work)	<input type="text"/>
First Language	<input type="text"/>	Cell Number	<input type="text"/>
Second Language	<input type="text"/>		

Healthcare Provider Details

Surname & Initials	<input type="text"/>	Practice No.	<input type="text"/>
Email Address	<input type="text"/>	Telephone	<input type="text"/>
Cell Number	<input type="text"/>		

Clinical Reasons for requesting PrEP

Details	<input type="text"/>
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Special Investigation Results (Please provide copies of reports)

	Test Done?	If Yes, specify results	Test Date
Baseline HIV Test*	<input type="button" value="Yes"/> <input type="button" value="No"/>	<input type="text"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Serum Creatinine/eGFR	<input type="button" value="Yes"/> <input type="button" value="No"/>	<input type="text"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Hepatitis B surface antigen (HepBsAg)	<input type="button" value="Yes"/> <input type="button" value="No"/>	<input type="text"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

*Require a negative ELISA result < 1 month old before we will approve treatment.

Medication	<input type="text"/>
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I understand that all personal clinical information supplied to the AfA programme will be used to determine access to specific benefits for the treatment of Pre-Exposure Prophylaxis (PrEP). AfA 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 healthcare provider, however, retains responsibility for your care, irrespective of the benefits so authorised.

I/we therefore, authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependant, to provide the AfA 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 AfA. 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 familiarise myself with the rules of the programme as amended from time to time.

I acknowledge that benefits authorised by the AfA 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 AfA.

I understand that acceptance onto AfA means that an AfA treatment support counsellor will contact me.

I herewith authorise AfA and its agents/medical staff to disclose the medical information to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

Patient's Signature	<input type="text"/>	Healthcare Provider Signature	<input type="text"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	
Medical Aid No	<input type="text"/>	Dep Code	<input type="text"/>	Patient Name	<input type="text"/>	<input type="text" value="Page 1 of 1"/>

