



HIV APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for enrolment on the Scheme's HIV Risk Management Programme.
2. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
3. Approval of medication on the Programme is subject to the rules of the Scheme and Momentum TYB clinical protocols.
4. You may contact the HIV Risk Management Team at 086 0103 228 or email wellbeing@rumed.co.za
5. Send completed forms via mail PO Box 1672, Port Elizabeth, 6000 or e-mail wellbeing@rumed.co.za

B. BENEFICIARY DETAILS

Scheme Option

Membership Number

Surname First Names

Title Date of Birth ID Number

Telephone number: Home Cellular

Email address

Postal Address Code

Preferred way of communication (please tick one option): Tel (H) Cellphone Email

C. HISTORY

Date of HIV Diagnosis: Test used: _____ (Please attach copy of positive test result)

Previous ARV Regime	Date Started	Date Stopped	Reason for Change
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Has Client been counselled? Y N By whom: _____

Is Client coping with diagnosis? Y N

Has Client disclosed HIV diagnosis? Y N If yes to whom: _____

Alternate Contact: Name Relationship Cellular

(Please confirm an alternative person that we can contact to discuss your care and management if needed)

HIV option: Pre- ART HAART PMTCT Paed (0 - 15years) PEP PrEP

(please note that PrEP is only available for sero-discordant couples on the HIV programme)

D. CLIENT DECLARATION

- I have received individual counselling and education on HIV/AIDS in a language that I understand and that I am able to make an informed decision on joining the HIV/AIDS Disease Management Programme (DMP).
- I understand the benefits and conditions of the HIV/AIDS DMP.
- I understand the purpose for doing pathology tests and that these tests are required as part of the HIV/AIDS DMP
- I understand that I will be contacted regularly by a case manager or other healthcare worker involved in my care
- I understand that, even though I am on the HIV/AIDS DMP, my doctor retains a responsibility for my care, irrespective of the benefits authorised.
- I understand that all personal and clinical information supplied to the HIV/AIDS DMP will be used to access and manage my HIV/AIDS benefits.
- I hereby give consent to the HIV/AIDS DMP to obtain my Medical Information from my healthcare provider (medical doctor, pharmacy, pathology & radiology)
- I authorise the HIV/AIDS DMP to disclose the clinical information relevant to my HIV condition without disclosure of my identity for the purpose of epidemiological/financial or scientific analysis and reporting
- I confirm that the information provided in this application is true and correct and that I voluntarily subscribe to the HIV/AIDS DMP
- I understand that the HIV/AIDS DMP shall use its best endeavours to uphold the confidentiality of all information related to my HIV condition
- I understand that calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the HIV department
- I acknowledge that my personal details are treated as confidential and I accept that the HIV DMP may use these contact details to communicate with me.

Patient Signature (or member if patient is a minor) _____

Date

Patient Name

Membership Number

E. CLINICAL INFORMATION AND EXAMINATION

Note: Investigation results are essential for registration on the Programme. Please provide copies of all recent pathology reports.

Current weight kg Height m

Is the member pregnant? Yes No If Yes, expected date of delivery

Does member consume alcohol? Yes No Does member use traditional/alternative medicines Yes No

Co-Morbidities: _____

Does member have any known allergies? Yes No If Yes, please provide details: _____

Please describe any abnormality on examination or previous significant illness: _____

Baseline Investigations (all required tests results must accompany application) Hepatitis B Cholesterol Glucose Creatinine

U & E FBC LFT RPR Pap Smear CRAG Other _____

TB Screen Symptomatic Investigations: CXR Sputum Is member a candidate for IPT?

F. SEROLOGICAL TESTS

Previous CD4 and Viral Load studies: (NB - please ensure that a Cryptococcal Antigen test is done for any CD4 count below 100) CRAG Result

CD4				VIRAL LOAD			
Date				Date			
Result				Result			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
_____ cells/mm ³ CD4% = _____ %				_____ copies/ml			
_____ cells/mm ³ CD4% = _____ %				_____ copies/ml			
_____ cells/mm ³ CD4% = _____ %				_____ copies/ml			

G. MEDICATION REQUIRED FOR HIV AND AIDS (to be completed by doctor)

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date medication initiated & prescriber details	Repeats

Please attach a copy of the prescription

H. MEDICAL PRACTITIONER DETAILS

Surname Initials

Practice number Speciality

Telephone number Cellular

Fax number

Email address

The following have been attached to this application: Confirmation of HIV status (ELISA) CD4 & Viral load result

Hb/ALT/CREATININE Prescription for medicine

The outcome of this application must be communicated to me via my email address: Yes No OR fax number Yes No

Signature of Medical Practitioner _____ Date

