

Patient's name and surname Membership number

2. Child or spouse details (to be completed by dependant applying for cover)

Title Initials Surname

First name(s) (as per identity document)

ID or passport number Date of birth

Relationship to main member Sex

Telephone (H) (W)

Cellphone Fax

Email address

May we communicate your confidential information to this email address? Yes No or fax number? Yes No or SMS Yes No

3. Legal declaration

I understand that Discovery must access my personal clinical information to make recommendations regarding my chronic medicines needs and to provide me with the full benefits of the Discovery HIVCare programme. I authorise any third party, disease management, previous scheme or healthcare professionals e.g. pathology, laboratories, doctors, hospitals etc. in possession of any medical information regarding my dependants (if minor) or myself to provide Discovery with any information that they may need with the exception of any information that I stipulate in writing may not be provided to Discovery. I acknowledge that my healthcare professional is responsible for my diagnosis and treatment.

I consent to Discovery disclosing to pharmacies and contracted providers of disease management programmes my information as is necessary to ensure that I receive the full benefits of the Discovery HIVCare programme. I understand that the pharmacies and providers are bound by obligations of confidentiality.

Member's signature

Date

4. Clinical data and examination (to be completed by the doctor)

Note: Investigation results are essential for registration. Please provide copies of recent reports (for the last three months)

Date of last test

More pathology investigations will be useful for a full clinical picture. Please provide copies of the following reports:

- Full blood count
- Liver function test
- Urea and creatinine

Is the patient pregnant? Yes No

If **yes**, expected date of delivery

Height (m) Weight (kg) BSA (for children)

5. Other clinical data required (to be completed by the doctor)

Date of diagnosis

1. Clinical staging (Centre for Disease Control or World Health Organisation)

2. Clinical information to substantiate staging in point 1

3. Drug history

Medicine	Duration of treatment	Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy
<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"/>

Reason/code for discontinuation: A Side effects B Cost C Resistance D Other

If **other**, please provide a brief explanation

Please specify any other medicine that the member uses on a regular basis

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6. Medicine required for HIV and AIDS (to be completed by the doctor)

The Discovery HIVCare Programme provides cover for disease-modifying therapy. Medicine used for symptomatic control is not covered.

Diagnosis	Date when condition was first diagnosed	Medicine name, strength and dosage	Number of repeats	How long has the patient used this medicine?		May we use a generic?	
				Years	Months	Yes	No

7. Address for delivery of medicine

Contact person

Address
 Code

Telephone (H) (W)

Cellphone Fax

8. Doctor's details (to be completed by the doctor)

Name

Telephone Fax

Practice email

BHF practice number

Preferred means of communication Email Fax

Doctor's signature Date

Note to doctor: The doctor's fee for completion of this form will be reimbursed on Code 0199 provided that the patient is a member of the scheme at the time of application. Payment of the claim will be made from the member's Medical Savings Account, subject to the member's benefit plan and availability of funds. Please also note that a new script will be needed by the pharmacy every six months.