HIVCare Programme application form 2020

Discovery
Health Medical Scheme

Who we are

Discovery Health Medical Scheme (referred to as 'the Scheme'), registration number 1125, is the medical scheme that you are applying to become a member of. This is a not-for-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

Contact us

Tel (members): 0860 99 88 77, Tel (health partner): 0860 44 55 66, PO Box 784262, Sandton, 2146, **www.discovery.co.za**, 1 Discovery Place, Sandton, 2196.

Purpose of the form

This application form is to join the HIV Care Programme and to apply for antiretroviral medicine. Visit **www.discovery.co.za** or click on Find a provider on the Discovery app to find a provider in our network. Please always look at the latest version of the medicine lists available at **www.discovery.co.za** > Find document.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Fill in section 1 and 2 of the application form and sign section 2.
- Take the form to your doctor to complete section 3 to 6 if you need medicine.
- Once we receive the application form for the medicine you need, we will call you to confirm your order.

A note to the treating healthcare professional.

Please remember to send the patient's most recent and relevant blood results with this form.

Send the completed and signed form to us by email **HIV_Diseasemanagement@discovery.co.za** or fax **011 539 3151** or post to **PO Box 536, Rivonia, 2128**

1. Patient details

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name

Gender F M | Date of birth D D - M M - Y Y Y Y

ID or passport number | Country of issue

Membership number | Telephone (H) -

Telephone (W) - | Cellphone -

Fax -

Email

The outcome of this application can be communicated to me by Email Fax

Please ensure your contact details are always up to date as we rely on this information keep you updated. You may update your details on www.discovery.co.za.

Signature of patient | Date D D - M M - Y Y Y Y

Please only sign if information is true, complete and correct.

2. Main member details (please ONLY complete this if the patient is a minor)

Title | Initials

Surname

First name(s) (as per identity document)

Preferred name

Gender F M | Date of birth D D - M M - Y Y Y Y

ID or passport number | Country of issue

Membership number | Telephone (H) -

Telephone (W) - | Cellphone -

Fax -

Email

Please ensure your contact details are always up to date as we rely on this information keep you updated. You may update your details on www.discovery.co.za.

Signature of patient | Date D D - M M - Y Y Y Y

Please only sign if information is true, complete and correct.

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

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

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- CD4 count
- Viral load
- Full blood count
- Liver function test
- Urea and creatinine

Is the patient pregnant? ☐ Yes ☐ No

If yes, expected date of delivery D D - M M - Y Y Y Y

Height ______ (m) Weight ______ (kg)

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

Date of diagnosis D D - M M - Y Y Y Y

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

4.2. Clinical information to substantiate staging in point 1

4.3. Medicine history

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

Reason or code for discontinuation: ☐ A) Side effects ☐ B) Cost ☐ C) Resistance ☐ D) Other

If other, please provide a brief explanation

4.4. Is the patient being treated for one or more of the below conditions (please check the appropriate block):

☐ Diabetes ☐ Epilepsy ☐ Hypercholesterolemia ☐ Depression/psychiatric treatment ☐ Tuberculosis (TB) ☐ Cancer

☐ Chronic renal failure ☐ Hypertension/Cardiac failure ☐ Other

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4.5. If “other”, please provide a brief explanation

4.6. List the medicine the patient is currently taking for the above condition/s (if applicable)

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

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

6. Doctor’s details (to be completed by the doctor)

Name and surname

BHF practice number

Telephone - Fax -

Email

The outcome of this application can be communicated to me by ☐ Email ☐ Fax

I acknowledge that the approval of this treatment is subject to the HIV status of the patient and that I have received the patient's consent to disclose their HIV status and any other related information to Discovery Health Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor Date D D - M M - Y Y Y Y

Please only sign if information is true, complete and correct.