

## Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, 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 partners): 0860 44 55 66, [www.discovery.co.za](http://www.discovery.co.za), PO Box 784262, Sandton, 2146,  
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](http://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](http://www.discovery.co.za) > under Medical Aid > Manage your health plan > Find important documents and certificates.

## 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 both sections.
- 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](mailto:HIV_Diseasemanagement@discovery.co.za) or post to **PO Box**

**536, Rivonia, 2128**, or you can submit this form on [www.discovery.co.za](http://www.discovery.co.za) under Medical Aid > Get Help > Submit a document and follow the guided steps through our Virtual Agent.

## 1. Patient details

Title	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Preferred name	<input type="text"/>		
Gender	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>
Membership number	<input type="text"/>	Telephone (H)	<input type="text"/> - <input type="text"/>
Telephone (W)	<input type="text"/> - <input type="text"/>	Cellphone	<input type="text"/> - <input type="text"/>
Email	<input type="text"/>		

The outcome of this application will be communicated to you by email.

**Please ensure your contact details are always up to date as we rely on this information to keep you updated. You can update your details on [www.discovery.co.za](http://www.discovery.co.za).**

Signature of patient (If patient is a minor, main member to sign)	<input type="text"/>	Date	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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 **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	<input type="text"/>	Initials	<input type="text"/>
Surname	<input type="text"/>		
First name(s) (as per identity document)	<input type="text"/>		
Preferred name	<input type="text"/>		
Gender	<input type="checkbox"/> F <input type="checkbox"/> M	Date of birth	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
ID or passport number	<input type="text"/>	Country of issue	<input type="text"/>
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/> - <input type="text"/>	Telephone (W)	<input type="text"/> - <input type="text"/>
Cellphone	<input type="text"/> - <input type="text"/>		
Email	<input type="text"/>		

**Please ensure your contact details are always up to date as we rely on this information to keep you updated. You can update your details on [www.discovery.co.za](http://www.discovery.co.za).**

Signature of patient	<input type="text"/>	Date	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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 **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:

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


4.2. Clinical information to substantiate staging in point 4.1


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

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?		Reason if no
				Years	Months	Yes	No	
HIV								
Opportunistic infections								

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

Name and surname

Practice number

Telephone  -

Email

The outcome of this application will be communicated to you by email.

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   -   -

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