

HIVCare Programme application form



NETCARE MEDICAL SCHEME
Administered by Discovery Health

Contact details

Tel: 0861 638 633 • PO Box 652509, Benmore, 2010 • www.netcaremedicalscheme.co.za

This application form is to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is available on the Netcare Medical Scheme, subject to the Scheme rules and the terms and conditions of the HIVCare Programme.

This form is valid for 2019, the latest version of the application form is available on www.netcaremedicalscheme.co.za

Who we are

Netcare Medical Scheme, registration number 1584, is a non-profit organization, registered with the Council for Medical Schemes.

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

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. **A note to the treating healthcare professional:** Please remember to send the patient's most recent relevant blood results with this form.
3. You (the member) must complete Section 1 to 2 of this form and sign section 2.
4. Your doctor must complete Section 3 to 7 if you need medicine.
5. Please fax this completed and signed form with any support documentation to **011 539 3151** or email it to **HIV@netcaremedicalscheme.co.za** or post it to **PO Box 536, Rivonia, 2128.**

1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>												
First name/s	<input type="text"/>														
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"/>	<input type="text"/>	ID or passport number	<input type="text"/>	<input type="text"/>	Sex	<input type="text"/>	<input type="text"/>
Membership number	<input type="text"/>														
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Work	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>														
Outcome of this application must be sent to me by:	Email	<input type="checkbox"/>	Fax	<input type="checkbox"/>											

2. Member information (if patient is a minor)

Title	<input type="text"/>	Surname	<input type="text"/>												
First name/s	<input type="text"/>														
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"/>	<input type="text"/>	ID or passport number	<input type="text"/>	<input type="text"/>	Sex	<input type="text"/>	<input type="text"/>
Membership number	<input type="text"/>														
Telephone (H)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Work	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Fax	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>														

Patient's signature (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"/>	<input type="text"/>	<input type="text"/>
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Patient's name and surname

Membership number

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 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

Height (cm) Weight (kg)

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

Date of diagnosis

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

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)

Patient's name and surname

Membership number

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 a generic medicine?	
				Years	Months	Yes	No
HIV							
Opportunistic infections							

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

Name

BHF practice number Telephone

Cellphone Fax

Email

The outcome of this application must be sent to me by Email or Fax

I confirm that I have received the patient's consent to disclose their HIV status and other medical information in this form to the Scheme and Discovery Health (Pty) Limited.

Doctor's signature

Date