

Request for pre-exposure prophylaxis (PREP)



Contact details

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

This application form is to register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for antiretroviral prophylaxis medicine is available subject to the Scheme Rules and the terms and conditions of the benefit. This form is valid for 2022.

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 for Netcare Medical Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the form is completed in full and signed by a healthcare professional.
3. Once complete, please email it to hiv@netcaremedicalscheme.co.za

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"/>	ID or passport number	<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"/>
Gender	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<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"/>
Telephone (H)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	(W)	<input type="text"/> <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"/> <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"/> <input type="text"/>
Email address	<input type="text"/>		

Outcome of this application must be sent to me by: Email Post

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

2. Main member details (Please ONLY complete this section if the 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"/>	ID or passport number	<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"/>
Gender	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<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"/>
Telephone (H)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	(W)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Cell phone	<input type="text"/> <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"/> <input type="text"/>
Email address	<input type="text"/>		

Patient's signature Date

(if patient is a minor, main member must sign)

Patient's name and surname

Membership number

3. Clinical data (to be completed by doctor)

Expected treatment start date

D	D	M	M	Y	Y	Y	Y
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Expected duration of treatment

Clinical reason for requesting PREP:

Patient's name and surname

Membership number

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Special investigation results (please provide copies of the reports):

	Test done?	If yes, specify results	Test date								
Baseline HIV test*	<input type="checkbox"/> Yes <input type="checkbox"/> No		<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Serum Creatinine/eGFR	<input type="checkbox"/> Yes <input type="checkbox"/> No		<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

*We require a negative ELISA result from a test completed within one month of the date of submission, before we will approve treatment.

4. Medicine (to be completed by doctor)

Medicine name	Dosage	Duration	May the patient use generics		If no, reason
			Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

Please specify any other medicine that the patient uses regularly

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

Name

BHF practice number

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 Telephone

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Fax

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Phone Number

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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 Netcare Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor

Date

D	D	M	M	Y	Y	Y	Y
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