PROVIDENCE
Healthcare Risk Managers

HIV RISK MANAGEMENT APPLICATION FORM

A. IMPORTANT INFORMATION

1. One application must be completed per beneficiary applying for enrolment on the Scheme's HIV Risk Management Programme.
2. It is essential that you submit all required information correctly and timeously as incomplete forms will not be processed.
3. Approval of medication on the Programme is subject to the rules of the Scheme and PROVIDENCE clinical protocols.
4. You may contact the HIV Risk Management Team at **086 0103 228** or email **wellbeing@providence.co.za**
5. Send completed forms via fax **0865994511**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **wellbeing@providence.co.za**

B. BENEFICIARY DETAILS

Scheme | Option

Membership Number

Surname | First Names

Title | Date of Birth (Y Y Y Y M M D D) | ID Number

Telephone number: Home | Cellular

Email address

Postal Address

Code

Preferred way of communication (please tick one option): Tel (H) ☐ Cellphone ☐ Email ☐

C. HISTORY

Date of HIV Diagnosis: (Y Y Y Y M M D D) Test used: _____ (Please attach copy of positive test result)

Previous ARV Regime	Date Started (Y Y M M D D)	Date Stopped (Y Y M M D D)	Reason forChange

Has Client been counselled? Y ☐ N ☐ By whom: _____

Is Client coping with diagnosis? Y ☐ N ☐

Has Client disclosed HIV diagnosis? Y ☐ N ☐ If yes to whom: _____

Alternate Contact: Name | Relationship | Cellular

(Please confirm an alternative person that we can contact to discuss your care and management if needed)

HIV option: ☐ Pre- ART ☐ HAART ☐ PMTCT ☐ Paed (0 - 15years) ☐ PEP ☐ PrEP

(please note that PrEP is only available for sero-discordant couples on the HIV programme)

D. CLIENT DECLARATION

- I declare that I have received individual counselling and education on HIV/AIDS in a language that I understand and that I am able to make an informed decision on joining the HIV/AIDS Disease Management Programme (DMP).
- I understand the benefits and conditions of the HIV/AIDS DMP.
- I understand the purpose for doing pathology tests and that these tests are required as part of the HIV/AIDS DMP
- I understand that I will be contacted regularly by a case manager or any other healthcare worker involved in my care
- I understand that, even though I am on the HIV/AIDS DMP, my doctor retains a responsibility for my care, irrespective of the benefits authorised.
- I understand that all personal and clinical information supplied to the HIV/AIDS DMP will be used to access and manage my HIV/ AIDS benefits.
- I hereby give consent to the HIV/AIDS DMP to obtain my Medical Information from my healthcare providers (medical doctor, pharmacy, pathology & radiology)
- I authorise the HIV/AIDS DMP to disclose the clinical information relevant to my HIV condition without disclosure of my identity for the purpose of epidemiological/financial or scientific analysis and reporting
- I confirm that the information provided in this application is true and correct and that I voluntarily subscribe to the HIV/AIDS DMP
- I understand that the HIV/AIDS DMP shall use its best endeavours to uphold the confidentiality of all information related to my HIV condition
- I understand that calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the HIV department
- I acknowledge that my personal details are treated as confidential and I accept that the HIV DMP may use these contact details to communicate with me.

Patient Signature (or member if patient is a minor) _____ Date (Y Y Y Y M M D D)

SABS ISO 9001

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Patient name

Membership number

E. CLINICAL INFORMATION AND EXAMINATION

Note: Investigation results are essential for registration on the Programme. Please provide copies of all recent pathology reports.

Current weight ____ kg Height ____ m

Is the member pregnant? Yes ☐ No ☐ If Yes, expected date of delivery Y Y Y Y M M D D

Does member consume alcohol? Yes ☐ No ☐ Does member use traditional/alternative medicines Yes ☐ No ☐

Co-Morbidities: _____

Does member have any known allergies? Yes ☐ No ☐ If Yes, please provide details: _____

Please describe any abnormality on examination or previous significant illness: _____

_____

_____

Baseline Investigations(all required tests results must accompany application) Hepatitis B ☐ Cholesterol ☐ Glucose ☐ Creatinine ☐

U & E ☐ FBC ☐ LFT ☐ RPR ☐ Pap Smear ☐ CRAG ☐ Other _____

TB Screen Symptomatic Y N Investigations: CXR Y N Sputum Y N Is member a candidate for IPT? Y N

F. SEROLOGICAL TESTS

Previous CD4 and Viral Load studies: (**NB** - please ensure that a Cryptococcal Antigen test is done for any CD4 count below 100) CRAG Result ☐

CD4		VIRAL LOAD	
Date	**Result**	**Date**	**Result**
Y Y Y Y M M D D	_____ cells/mm³ CD4% = _____ %	Y Y Y Y M M D D	_____ copies/ml
Y Y Y Y M M D D	_____ cells/mm³ CD4% = _____ %	Y Y Y Y M M D D	_____ copies/ml
Y Y Y Y M M D D	_____ cells/mm³ CD4% = _____ %	Y Y Y Y M M D D	_____ copies/ml

G. MEDICATION REQUIRED FOR HIV AND AIDS (to be completed by doctor)

ICD-10 Code	Medication prescribed (Name, strength & dosage)	Date medication initiated & prescriber details	Repeats

Please attach a copy of the prescription

H. MEDICAL PRACTITIONER DETAILS

Surname _____ Initials _____

Practice number _____ Speciality _____

Telephone number _____ Cellular _____

Fax number _____

Email address _____

The following have been attached to this application: Confirmation of HIV status (ELISA) ☐ CD4 & Viral load result ☐

Hb/ALT/CREATININE ☐ Prescription for medicine ☐

The outcome of this application must be communicated to me via my email address: Yes ☐ No ☐ **OR** fax number Yes ☐ No ☐

Signature of Medical Practitioner _____ Date Y Y Y Y M M D D

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