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 **aids@providence.co.za**
5. Send completed forms via fax **(041) 395 4599**, mail **PO Box 1672, Port Elizabeth, 6000** or e-mail **aids@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) | (Work)

Fax number | Cellular

Email address

Postal Address

Code

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

C. HISTORY

Date of HIV Diagnosis: (Y Y Y Y M M D D) Test used: _____

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 the client coping with diagnosis: Y ☐ N ☐

Has client disclosed his status: Y ☐ N ☐ If yes to whom: _____

D. PATIENT DECLARATION

By signing below, I hereby give permission for, acknowledge and/or agree to the following:

- I hereby confirm that the information provided in this application is true and correct.
- Any information concerning this application will remain confidential at all times.
- I acknowledge that PROVIDENCE is the administrator of the Programme and that any anti-retroviral treatment prescribed as well as the general management of my HIV condition shall be the sole responsibility of my medical practitioners. PROVIDENCE and my Medical Scheme shall accordingly not be liable for any claims by me or my dependants arising from the implementation of the Programme.
- I hereby give my consent to my medical practitioner to provide the Programme's Case Managers with clinical information pertinent to the management of my HIV infection. I furthermore agree to the Programme's Case Managers sharing this information with any other healthcare worker involved in my care (including hospital risk management professionals appointed by the Scheme).
- I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care.
- Whilst PROVIDENCE shall use its best endeavours to uphold the confidentiality of all information disclosed to it, PROVIDENCE shall not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to a third party.
- I shall be entitled to terminate my participation in the Programme at any time with immediate effect, but understand that:
  - all the benefits that I enjoy under the Programme shall immediately cease and the Scheme shall not be obliged to reinstate such benefits at any time thereafter, and
  - that the consequences of such a decision will rest with me alone.
- I acknowledge that should I not comply with the Programme protocols or prescribed treatment, that the Scheme at its sole discretion may elect to exercise its rights and limit my benefits to the Prescribed Minimum Benefits as legislated.

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

SABS ISO 9001

Administered by PROVIDENCE Healthcare Risk Managers (Pty) Ltd. Reg. No.1993/006699/07
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Version 3
Effective Date: 07 March 2012

Authorised by: Chistina Gubeni

Patient name

Membership number

E. CLINICAL INFORMATION AND EXAMINATION (to be completed by doctor)

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

Current weight ____ kg Height ____ m Body Surface Area (for children) ____ m²

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 below: _____

_____

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

_____

_____

Baseline Investigations: (please indicate which have been done) Hepatitis B ☐ Cholesterol ☐ Glucose ☐ Creatinine ☐

U & E ☐ FBC ☐ LFT ☐ RPR ☐ TB test ☐ Pap Smear ☐ Other _____

F. SEROLOGICAL TESTS (to be completed by doctor)

Previous CD4 and Viral Load studies:

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
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 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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