

# HIVCare Programme application form

## Contact us

Tel: 0860 00 21 41 • PO Box 652509, Benmore 2010 • [www.glencorememberscheme.co.za](http://www.glencorememberscheme.co.za)

This application form is to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is 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.glencorememberscheme.co.za](http://www.glencorememberscheme.co.za)

### Who we are

The Glencore Medical Scheme (referred to as 'the Scheme'), registration number 1253, is a non-profit organisation, 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). We take care of the administration of your membership for the Scheme.

### How to complete this form

#### What you must do

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 6 if you need medicine.
5. Please fax this completed and signed form with any support documentation to **011 539 3151** or email it to **[medicalscheme.hivprogramme@glencore.co.za](mailto:medicalscheme.hivprogramme@glencore.co.za)** or post it to **PO Box 536, Rivonia, 2128.**

## 1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First names	<input type="text"/>		
Date of birth	<input type="text"/>	ID or passport number	<input type="text"/>
			Sex <input type="text"/>
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Work	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		

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

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

## 2. Main member details (Please complete this section if the patient is a minor)

Title	<input type="text"/>	Surname	<input type="text"/>
First names	<input type="text"/>		
Date of birth	<input type="text"/>	ID or passport number	<input type="text"/>
			Sex <input type="text"/>
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	Work	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		

Patient's signature (if patient is a minor, main member to sign)  Date

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 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 a generic medicine?	
				Years	Months	Yes	No
HIV							
Opportunist infection							

Patient's name and surname

Membership number

**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  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.**

Signature of doctor

Date