HIVCare Programme application form

GLENCORE
Medical Scheme

Contact details
Tel: 0860 00 21 41 • PO Box 652509, Benmore 2010 • www.glencoremedicalscheme.co.za

This application form is to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is subject to theScheme rules and the terms and conditions of the HIVCare Programme.
This form is valid for 2020, the latest version of the application form is available on www.glencoremedicalscheme.co.za

Who we are
The Glencore Medical Scheme (referred to as 'the Scheme'), registration number 1253, is a not-for-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 professiona**l: 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 or post it to PO Box 536, Rivonia, 2128.**

1. Patient details

Title
Surname
First name/s
Date of birth D D M M Y Y Y Y
ID or passport number
Gender M F
Membership number
Telephone (H) (W)
Cellphone Fax
Email address
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.glencoremedicalscheme.co.za

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

Title Surname
First name/s
Date of birth D D M M Y Y Y Y
ID or passport Number Sex M F
Membership number Telephone (H)
Work (W) Cellphone (C)
Fax (F)
Email address
Patient's signature Date D D - M M - Y Y Y Y

If patient is a minor,main member must sign

GLEHPA001

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 D D M M Y Y Y Y

Height ☐☐☐☐ (cm) Weight ☐☐☐☐ (kg)

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

Date of diagnosis D D M M Y Y Y Y

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: ☐ Side effects ☐ Cost ☐ Resistance ☐ 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	Reason if no
HIV								
Opportunistic infections								

We will approve funding for generic medicine where available, unless you have indicated otherwise

6. Doctor's details (doctor to complete)

Name and Surname

BHF practice number Telephone -

Cellphone Fax

Email

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

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 ~~Discovery Health~~ Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor

Date D D - M M - Y Y Y Y

⚠ Please only sign if information is true, complete and correct.