ANGLOVAAL GROUP MEDICAL SCHEME

Administered by Discovery Health

Contact details
Tel: 0860 100 693 • PO Box 652509, Benmore 2010 • www.avgms.co.za

Request for pre-exposure prophylaxis (PREP) 2019

Who we are

The Anglovaal Group Medical Scheme (referred to as 'the Scheme'), registration number 1571, 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.

What you must do

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_Diseasemanagement@discovery.co.za**

1. Patient details

Title | Surname

First name/s

Date of birth (Y Y Y Y M M D D) | ID or passport number | Sex (M F)

Membership number

Telephone (H) | Work (W)

Cellphone (C) | Fax (F)

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.avgms.co.za

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

Title | Surname

First name/s

Date of birth (Y Y Y Y M M D D) | ID or passport number | Sex (M F)

Membership number

Telephone (H) | Work (W)

Cellphone (C) | Fax (F)

Email address

Patient's signature (if patient is a minor, main member must sign) — Original hand signature required

Date (Y Y Y Y M M D D)

3. Clinical data (to be completed by doctor)

Expected treatment start date: Y Y Y Y M M D D

Expected duration of treatment:

Clinical reason for requesting PREP:

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

	Test done?		If yes, specify results	Test date
Baseline HIV test*	☐ Yes	☐ No		Y Y Y Y M M D D
Serum Creatinine/eGFR	☐ Yes	☐ No		Y Y Y Y M M D D

*Require a negative ELISA result < 1 month old before we will approve treatment.

Patient's name and surname

Membership number

4. Medicine (to be completed by doctor)

Medicine	Dosage	Duration of treatment

Please specify any other medicine that the patient uses regularly

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

Name

BHF practice number

Telephone

Cellphone (C)

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 Anglovaal Group Medical Scheme and Discovery Health (Pty) Ltd.

Signature of doctor: Original hand signature required

Date: Y Y Y Y M M D D