HIV*Care* Programme application form

Contact details
Tel: 0860 103 933 • PO Box 652509, Benmore 2010 • www.lahealth.co.za

This application form is to join the HIVCare Programme and to apply for antiretroviral medicine. Cover for antiretroviral medicine is available on all plans, subject to the Scheme rules and the terms and conditions of the HIVCare Programme.

If you are on a LA Comprehensive, LA Core, LA Active or LA Focus option, you must use a Premier Plus HIV Network GP to manage your condition to avoid a 20% co-payment on consultations.

If you are on a LA KeyPlus option, you must make use of a LA KeyCare Network GP and a Premier Plus HIV Network GP to avoid a 20% co-payment on consultations. Additionally, if you are on the KeyPlus option Please log on to the LA Health website **(www.lahealth.co.za)** to confirm a Designated Service Provider pharmacy near you or contact MedXpress.

Please always look at the latest version of the medicine lists available at **www.lahealth.co.za**

Who we are

LA Health Medical Scheme (referred to as 'the Scheme'), registration number 1145, 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

1. Please use one letter per block, complete in black ink and print clearly.
2. 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 **HIV_Diseasemanagement@discovery.co.za** or post it to PO Box 536, Rivonia, 2128.
6. You can also contact our call centre on 0860 103 933 if you have any questions.

1. Patient details

Title Surname

First names

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

Membership number

Telephone (H) Work

Cellphone Fax

Email

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 to keep you updated. You may update your details on www.lahealth.co.za

Patient's name and surname

Membership number

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

Title Surname

First names

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

Membership number

Telephone (H) Work

Cellphone Fax

Email

Main member's signature

Date (Y Y Y Y M M D D)

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 (Y Y Y Y M M D D)

Height (cm) Weight (kg)

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

Date of diagnosis (Y Y Y Y M M D D)

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)

Patient's name and surname

Membership number

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 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 (to be completed by the doctor)

Name

Telephone

Fax

Practice email

Practice number

The outcome of this application must be sent to me by Email ☐ or 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.

Doctor's signature

Date Y Y Y Y M M D D