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) 2022

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

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 (D D M M Y Y Y Y) | ID or passport number

Gender M F

Race African | Coloured | Indian/Asian | White | Other

This information is required by the Council for Medical Scheme for statistical purposes. You are not compelled to provide this information.

Do not want to disclose.

Membership number

Telephone (H) | (W)

Cellphone (C) | (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 names

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)

Please note that this form expires on 31/03/2023. Up to date forms are available on www.avgms.co.za.

3. Clinical data (to be completed by doctor)

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

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		D D M M Y Y Y Y
Serum Creatinine/eGFR	Yes	No		D D M M Y Y Y Y

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

4. Medicine (to be completed by 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

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

Date D D M M Y Y Y Y