HIV/AIDS Management Programme Form

Please complete in block capitals

Libcare

Contact details
Tel: 0800 12 CARE (2273) • P.O. Box 653418, Benmore, 2010 • www.libcare.co.za

Who we are

Libcare Medical Scheme, registration number 1197, is a not-for-profit organisation registered with the Council for Medical Schemes, and is the medical scheme that you are a member of.

Liberty Health Administration (Pty) Limited, registration number 2004/006809/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Liberty medical Scheme and takes care of the administration of your membership.

Contact us

Should you require any further information, you can call the Libcare Contact Centre on 0800 12 CARE (2273) or email care@libcare.co.za. The Libcare Contact Centre is operational Monday to Friday from 08:00 to 17:00, excluding public holidays. Website: www.libcare.co.za Postal address: PO Box 653418, Benmore, 2010

Purpose of the form

This application form is to join the HIV/AIDS Management Programme and to apply for antiretroviral medicine.

What you must do

- Fill in the form in black ink and print clearly, or complete the form digitally.
- All relevant sections must be physically signed and cannot be signed digitally. The patient must sign and date any changes.
- Fill in section A of the application form and sign Section G.
- Take the form to your doctor to complete section B to F.

A note to the treating healthcare professional

Please remember to send the patient's most recent and relevant blood results with this form.

Send the completed and signed form to us by email care@libcare.co.za or post to PO Box 653418, Benmore, 2010

SECTION A: GENERAL PATIENT INFORMATION

Name of Principal member

Name of patient

Membership number

Patient dependant code

ID number

Gender M F

Date of birth D D M M Y Y Y Y

Home telephone (please include area code)

Work telephone (please include area code)

Cellphone

Email address

Postal address

Postal Code

Physical address

Postal Code

Preferred method of communication Telephone Email

SECTION B: GENERAL CLINICAL EXAMINATION AND MEDICAL HISTORY (to be completed by the doctor)

Weight (kg) | Height (cm) | Blood pressure

Pulse | Smoking Yes No | Alcohol use Yes No

Condition	√	Date Diagnosed	Treatment
Malaria		D D M M Y Y Y Y	
Tuberculosis		D D M M Y Y Y Y	
Stroke		D D M M Y Y Y Y	
Ischaemic Heart Disease		D D M M Y Y Y Y	
Diabetes		D D M M Y Y Y Y	
Asthma		D D M M Y Y Y Y	
Dyslipidaemia		D D M M Y Y Y Y	

Drug Allergies

Currently pregnant? Yes No EDD GRAVIDA PARA

Current method of contraception

SECTION C: HIV CLINICAL DETAILS (to be completed by the doctor)

Date of diagnosis D D M M Y Y Y Y

Test used in diagnosis

HIV/AIDS related symptoms and opportunistic infections

1. Nervous system
2. Ear, nose and throat
3. Respiratory
4. Gastrointestinal
5. Urogenital/Renal
6. Skin
7. General

LIBHPR001

8. WHO Staging 1 2 3 4

SECTION D: TEST RESULTS

1. CD4 count and percentage

Date	Results
D D - M M - Y Y Y Y	
D D - M M - Y Y Y Y	
D D - M M - Y Y Y Y	
D D - M M - Y Y Y Y	

2. Viral load

Date	Results
D D - M M - Y Y Y Y	
D D - M M - Y Y Y Y	
D D - M M - Y Y Y Y	
D D - M M - Y Y Y Y	

3. Please list other abnormal results / fax copy of results

4. Antiretroviral and prophylactic medication requested

Name	Dosage

5. Previous antiretroviral medication

Name	Started	stopped	Reason
	D D M M Y Y Y Y	D D M M Y Y Y Y	
	D D M M Y Y Y Y	D D M M Y Y Y Y	
	D D M M Y Y Y Y	D D M M Y Y Y Y	
	D D M M Y Y Y Y	D D M M Y Y Y Y	

6. Current chronic medication

Name	Dosage

SECTION E: DOCTOR'S DETAILS (to be completed by the doctor)

Doctor's last name | Initials

Practice number

Work telephone (please include area code)

Mobile (please include area code)

Email address

SECTION F : DECLARATION BY TREATING DOCTOR

I hereby confirm that I have physically examined the programme applicant and have accurately recorded my findings in this application form. I understand that Libcare or the Administrator may contact me from time to time to request a clinical update including pathology and radiology test results, discuss treatment options and inform me of the programme benefits.

Doctor's signature

Date D D M M Y Y Y Y

SECTION G : DECLARATION BY PATIENT

Libcare Medical Scheme and its Administrator, Liberty Health Administration (Pty) Limited ("the Administrator"), are required to collect some of your personal information in order to enrol you in the HIV/AIDS Management Programme. Without your personal information we may be unable to start or continue to provide services to you.

Definitions

- **"Personal Information"** means information about an identifiable, natural or juristic person, including but not limited to, information about race, gender, sex, marital status, nationality, ethnic or social origin, colour, sexual orientation, age, physical or mental health, religion, belief, disability, language, birth, education, identity number, telephone number, email, postal or street address, biometric information and financial, criminal or employment history as well as correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence; and
- **"Process"** means any operation or activity, whether automated or not, concerning Personal Information, including: collection; receipt; recording; organisation; collation; storage; updating or modification; retrieval; alteration; consultation; use; dissemination by means of transmission, distribution or making available in any other form; merging, linking, as well as blocking, degradation, erasure or destruction of information. Processing has a similar meaning.

1. I hereby consent to Libcare and the Administrator receiving and requesting my blood test results, radiology and any on-going clinical information pertaining to my health as well as receiving any other information relating to my management on the HIV/AIDS management programme.
2. I also authorise Libcare and the Administrator to collect, process and share my Personal Information to manage my health in terms of the HIV/AIDS Management Programme.
3. I understand that the authorisation applies only for the purposes above and therefore may partially limit my right to privacy.
4. I understand that I am entitled at any time to request access to, update or rectify my Personal Information, through contacting the programme.

Libcare or the Administrator will notify you when your Personal Information has been compromised. We undertake to only process Personal Information as permitted by law. We undertake to keep your Personal Information confidential, secure and only for as long as required and prescribed.

Signed at | on D D - M M - Y Y Y Y

Signature of Applicant (Guardian/Parent)