

# HIV/AIDS Management Programme Form

Please complete in block capitals



## Contact us

Tel: 0800 12 CARE (2273) • PO Box 653418, Benmore 2010 • [www.libcare.co.za](http://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.

Discovery Administration Services (Pty) Ltd, 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](mailto:care@libcare.co.za). The Libcare Contact Centre is operational Monday to Friday from 08:00 to 17:00, excluding public holidays.

## 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](mailto:care@libcare.co.za) or post to PO Box 653418, Benmore, 2010

## Section A: General patient information

Name of Principal member	<input type="text"/>																
Name of patient	<input type="text"/>																
Membership number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Patient dependant code	<input type="text"/>	<input type="text"/>	<input type="text"/>		
ID number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Gender	M <input type="checkbox"/>	F <input type="checkbox"/>		
Date of birth	D	<input type="text"/>	D	<input type="text"/>	M	<input type="text"/>	M	<input type="text"/>	Y	<input type="text"/>	Y	<input type="text"/>	Y	<input type="text"/>	Y	<input type="text"/>	
Telephone (H) (please include area code)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Telephone (W) (please include area code)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Cellphone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Email address	<input type="text"/>																
Postal address	<input type="text"/>																
	<input type="text"/>												Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Physical address	<input type="text"/>																
	<input type="text"/>												Postal code	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Preferred method of communication	Telephone	<input type="checkbox"/>	Email	<input type="checkbox"/>													

**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	<input type="checkbox"/>	D D M M Y Y Y Y	
Tuberculosis	<input type="checkbox"/>	D D M M Y Y Y Y	
Stroke	<input type="checkbox"/>	D D M M Y Y Y Y	
Ischaemic Heart Disease	<input type="checkbox"/>	D D M M Y Y Y Y	
Diabetes	<input type="checkbox"/>	D D M M Y Y Y Y	
Asthma	<input type="checkbox"/>	D D M M Y Y Y Y	
Dyslipidaemia	<input type="checkbox"/>	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

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

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 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	<input type="text"/>	Initials	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Work telephone (please include area code)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mobile (please include area code)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>						

## 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	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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## Section G: Declaration by patient

Libcare Medical Scheme and its Administrator, Discovery Administration Services (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.
5. **Consent withdrawal for your Disease Management Benefits**  
Withdrawing consent for your general, personal, medical or clinical information to be accessed or shared with relevant third parties, means that you will no longer have access to funding from the applicable disease management benefits. Claims which would usually be funded from the disease management benefits will, once consent is withdrawn, be funded from other available benefits according to the rules of your plan. Should you wish to continue with the consent withdrawal process, then please email [care@libcare.co.za](mailto:care@libcare.co.za).

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 (town or city)	<input type="text"/>	on	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of Applicant (Guardian/Parent)	<input type="text"/>								