HIV YourLife PROGRAMME

Wooltru Healthcare

APPLICATION FORM

PRE-EXPOSURE PROPHYLAXIS (PrEP)

PATIENT DETAILS AND CONFIDENTIAL CONTACT DETAILS

Membership number ☐ Network Option ☐ Saver Option ☐ Comprehensive Option

Surname Dependant code

First name Title

ID number Gender ☐ Male ☐ Female

Date of birth D D M M Y Y Y Y

Telephone numbers Home Work

Patient's preferred cell phone number

Email address

Preferred postal address

Postal code

☐ My delivery address is the same as my postal address

Preferred delivery address (for medication)

Postal code

PATIENT CONSENT (TO BE SIGNED BY THE MAIN MEMBER OR GUARDIAN IF PATIENT IS A MINOR)

1. I hereby confirm that the information provided in this application is true and correct.
2. I agree to the terms and conditions and consent to participate on the HIV YourLife Programme.
3. I acknowledge that Momentum Health (Pty) Limited administers the HIV YourLife Programme that manages HIV and the treatment of my condition and that any antiretroviral treatment as well as the general management of my HIV condition shall be the sole responsibility of my medical practitioners. The HIV YourLife Programme, the Fund and my employer shall accordingly not be liable for any claims by me or my dependants arising from the implementation of any treatment prescribed by my medical practitioner.
4. I authorise, and give consent to the HIV YourLife Programme to collect, store, collate, process, share and further process my personal information, including health information, and that of my dependants, for purposes of belonging to the programme. I hereby authorise the HIV YourLife Programme to disclose my medical information to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
5. I authorise and give consent to the HIV YourLife Programme and its' employees to obtain my medical information from my healthcare providers (pharmacy, pathologist, medical doctor, radiologist and from any relevant healthcare service provider) to assess my medical risk and enrol me on the HIV YourLife Programme and to use such information to manage my condition as effectively as possible.
6. I understand that all my personal information shared with the HIV YourLife Programme and the Fund by me or any third party will not be shared with my employer without my written consent.
7. I shall be entitled to terminate my participation on the HIV YourLife Programme at any time with immediate effect and I understand the consequences of taking that decision to not be have my condition managed in an effective manner.
8. I have the right to withdraw my consent to have my personal information processed provided that the lawfulness of the processing of my personal information before my withdrawal will not be affected.
9. I understand that calls and written correspondence will be recorded for internal clinical quality assurance purposes and will not be shared with any third party other than the HIV YourLife Programme and the Fund.

I acknowledge that my details provided in this application form are treated as confidential and I accept the HIV YourLife Programme may use the contact details provided on this form to communicate with me.

Signed (patient/main member/parent/guardian) Date D D M M Y Y Y Y

Doctor's practice no.

DOCTOR'S DETAILS AND CONSENT

Surname

Initials

Practice number

Provider discipline

Physical address

Postal code

Telephone numbers Work Cell phone

Fax

Email address

I confirm that the clinical details described in this document are to my knowledge accurate and correct. I understand that the HIV YourLife Programme treatment protocols are guidelines only and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's HIV condition will reside with me. The reimbursement of therapy and related costs by the Fund will be in accordance with the guidelines as well as the benefit available to the above patient from time to time.

Doctor's signature

Date D D M M Y Y Y Y

INDICATIONS FOR USE

☐ MSM (males who have sex with males) ☐ Discordant couples ☐ Other (please motivate below)

TREATMENT REQUESTED

MEDICATION	DOSE	MEDICATION	DOSE

PLEASE NOTE: Include a prescription for the medication recommended for treatment.

BLOOD TESTS REQUIRED FOR PATIENT AT RISK OF EXPOSURE

Creatine or eGFR results _____ Date of test D D M M Y Y Y Y

HIV ELISA results _____ Date of test D D M M Y Y Y Y

Hepatitis B results _____ Date of test D D M M Y Y Y Y

Follow-up test:

Please provide patient with lab request form for follow-up test.

- HIV ELISA test to be repeated at six (6) weeks and three (3) months.

Membership no. Patient name and surname

03/2022