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HIV Programme Registration Form

IMPORTANT NOTE: This form must be completed by the treating doctor. Attach the prescription and supporting documentation (laboratory results or motivation) to the application and send via email to hivdmp@primecure.co.za.

Date: _____

A Prime Cure Network Doctor Details:

Doctor: _____ Practice Number: _____ Email: _____

Tel: _____ Fax: _____ Cell: _____

B Details of Principal Member/Policyholder:

Gender: ◯ Male ◯ Female Age: _____ Tel: _____ Cell: _____

Surname: _____ Identity Number: _____

First Name: _____ Medical Scheme/Health Insurer: _____

Plan/Option: _____ Member Number: _____ Dep Code: _____

C HIV Medical History

Date of diagnosis: _____

Previous HIV related illnesses/hospitalisations:

1. Reason for Admission: _____ Year: _____
2. Reason for Admission: _____ Year: _____

Other chronic ilnesses/hospitalisations:

1. Reason for Admission: _____ ICD-10 Code: _____ Treatment: _____
2. Reason for Admission: _____ ICD-10 Code: _____ Treatment: _____

D Clinical Assessment:

Weight: _____ kg Height: _____ m WHO Clinical Stage: _____

Comments: _____

HIV Pathology Results			
CD 4 cell count:	Date:	Result:	/mm3
CD4% (Child < 12 years):	Date:	Result:	%
VL:	Date:	Result:	copies/ml

RPR: _____ Date: _____ Hep B sAg Pos: ◯ Neg: ◯ Date: _____

E Treating or Allocated Doctor Details:

If different to Prime Cure Network doctor details

Doctor: _____ Practice Number: _____ Email: _____

Tel: _____ Fax: _____ Cell: _____

F Current Regime Requested:

Details

Doctor: _____ Doctor Signature: _____

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G Member/Policyholder Consent:

I, the undersigned,

- Declare that I have received individual counselling and education on HIV/AIDS in a language that I understand and that I am able to make an informed decision on joining the Prime Cure Disease Management Programme ("the Programme").
- Confirm that the information provided in this application is true and correct and that I voluntarily subscribe to become part of the Programme.
- Understand the purpose of doing pathology tests, i.e. ongoing monitoring of clinical management and treatment of my HIV/AIDS condition.
- Also understand:
  - Why my HIV/AIDS status and subsequent monitoring and tests are required as part of the Programme
  - That I may contact Prime Cure for further information and counselling if required
- Voluntarily consent to the drawing of blood samples to monitor and treat my HIV/AIDS condition
- Acknowledge that Prime Cure Health (Pty) Ltd, Registration Number: 1997/017429/07 ("Prime Cure") is the administrator of the Programme and that any anti-retroviral treatment prescribed, as well as the general management of my HIV/AIDS condition, shall be the sole responsibilityof the selected medical practitioners from the preferred provider network of Prime Cure. Prime Cure and my medical scheme ("the scheme") shall accordingly not be liable for any claims by me or my dependants arising from my participation in the Programme.
- May terminate my participation in the Programme with immediate effect, but understand that the consequences of such a decision will rest with me alone and that all benefits that I enjoy under the Programme shall then immediately cease, and that the scheme shall not be obliged to reinstate such benefits thereafter.
- Acknowledge that should I not comply with the Programme protocols or prescribed treatment, the scheme, at its sole discretion, may elect to exercise its rights to limit benefits to the statutory prescribed minimum benefits.
- Consent:
  - To the health care workers responsible for my treatment and/or management in terms of the Programme providing the Programme's case managers with clinical information about my HIV/AIDS infection, and the treatment and management thereof.
  - To the Programme's case managers sharing the above-mentioned information with any other health care worker involved with my care or management (including hospital risk management professionals appointed by the scheme or the scheme's administrator). Provided that no clinical information regarding my HIV/AIDS status will be available to my employer(s) or any other person not involved in my health care, or case management, without my express written consent.
- Acknowledge that whilst Prime Cure shall use its best endeavours to uphold the confidentiality of all information disclosed to it, Prime Cure shall not be liable for any claims by me or my dependants arising from any unintentional unauthorised disclosure of my personal information, my HIV/AIDS status, and the treatment and management thereof to a third party; or
- As a result of Prime Cure having to use ICD 10 codes when filing a claim for payment with the scheme.

Signed at: _____ Date _____

Full Names: _____ Surname: _____

AS WITNESS:

Name & Surname: _____ Surname: _____

Name & Surname: _____ Surname: _____