Application Form Confidential

AfA does not dispense medication - Please email this completed form to **afa@afadm.co.za**
This page needs to be completed by - The Applicant I Applications will be rejected unless signed by both Applicant and Healthcare Provider

Principal (Main) Member Details

First Name | Surname
Medical Scheme | Gender: Male / Female
Membership No. | Option / Plan

Patient Details

First Name | Surname
Dependant Code | Gender: Male / Female
ID Number | Date of Birth: D D M M Y Y Y Y

Treatment Support is a vital part of the AfA programme. Contact details must be supplied to enable us to provide you with this support.

Confidential Email
Preferred form of communication: Email / Print to SMS | Telephone (Home)
First Language | Telephone (Work)
Second Language | Cell Number

Next of kin or buddy who can be contacted if we cannot reach you (should know your HIV status)

First Name | Telephone (Home)
Surname | Telephone (Work)
Cell Number

I understand that all personal clinical information supplied to the AfA programme will be used to determine access to specific benefits for people with HIV infection. AfA will take all reasonable steps to maintain confidentiality. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. Your healthcare provider, however, retains responsibility for your care, irrespective of the benefits so authorised.

I/we therefore, authorise any healthcare provider, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependant (also newly born baby), to provide the AfA programme with information that it may require.

I warrant that the information in this application form is correct.

I acknowledge that completion of the application form does not automatically entitle me to any benefits and that acceptance to the programme is within the sole discretion of AfA. I acknowledge that I am familiar with the conditions and benefits of the programme, notwithstanding representation by any other party; and agree to abide by and undertake to familiarise myself with the rules of the programme as amended from time to time.

I acknowledge that benefits authorised by the AfA programme are subject to scheme rules and that non-adherence to the programme could result in my benefits from this programme being cancelled. I acknowledge that I will be responsible for any co-payments as per scheme rules or payment for any medication and/or investigations not authorised by AfA.

I understand that acceptance onto AfA means that an AfA treatment support counsellor will contact me.

I herewith authorise AfA and its agents/medical staff to disclose the medical information relevant to my HIV infection to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

Patient's Signature | Date: D D M M Y Y Y Y

Medical Aid No | Dep Code | Patient Name

Application Form Confidential

AfA does not dispense medication - Please email this completed form to **afa@afadm.co.za**
This page needs to be completed by - The Healthcare Provider

Healthcare Provider Details

Surname & Initials | Practice No.

Email Address

Telephone

Cell Number

Clinical History

When was HIV infection first diagnosed? (Please attach reports)

Type of screening test | Test date D D M M Y Y Y Y

Type of confirmatory test | Test date D D M M Y Y Y Y

Has the patient previously been exposed to antiretrovirals? Yes - MTCT prophylaxis | Yes - Other | No

If YES, please provide details - Note: If the application is for a baby please list mom's previous ART history.

ART Regimen	Start Date	End Date	Duration (Months)	Reason for discontinuation

Current combination patient is taking | Start Date D D M M Y Y Y Y

Is the patient currently being treated for Tuberculosis? Yes | No

If YES, specify start date D D M M Y Y Y Y | Duration

Is the patient currently taking a Rifampicin containing TB regimen? Yes | No

Is the patient currently taking a Metformin dose> 2g daily? Yes | No

Is the patient currently taking Phenytoin, Carbamazepine or Phenobarbitone? Yes | No

Is the patient currently taking Proton Pump Inhibitors? Yes | No

Please list any other medication the patient is taking, including prophylaxis

Is the patient allergic to sulphonamides? Yes | No

Other allergies? Yes | No | If YES, specify

Medical Aid No | Dep Code | Patient Name

Application Form Confidential

AfA does not dispense medication - Please email this completed form to **afa@afadm.co.za**
This page needs to be completed by - The Healthcare Provider

Clinical Examination

Weight ____ kg

Height ____ cm

Has the patient been diagnosed with any WHO Clinical Stage 3 or 4 conditions? Yes / No

If YES, please provide details

Has the patient been diagnosed with chronic renal disease? Yes / No

Is there any other significant clinical finding? Yes / No

Pregnant Yes / No

If YES, specify:

Expected date of delivery D D M M Y Y Y Y

Expected mode of delivery NVD / C/S

Expected date of C/S D D M M Y Y Y Y

If YES, please specify

Special Investigation Results (Please provide copies of reports. Supply as many results as possible, including baseline results)

Date Test Performed (DD/MM/YYYY)	CD4 count (cells/mm³)	CD4% (must be provided for children)	Viral Load (copies/mL)

Additional Investigations	Test Done?	If yes, specify results	Test Date
Serum creatinine/eGFR (Essential for patients with renal failure or prior to approval of Tenofov1r)	Yes / No		D D M M Y Y Y Y

Medication (Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated)

Antiretroviral Therapy	Strength (e.g. 10mg)	Directions (e.g. 1 tds)	Period in use (months)	Period required (months)

Other Medication Required (Associated with the management of HIV)

Diagnosis	Medication	Strength (e.g. 10mg)	Directions (e.g. 1 tds)	Period in use (months)	Period required (months)

Acknowledgement by Examining Healthcare Provider

Please Note:

- Tariff code 0199 will only be paid for the first time completion of the application form. The form must be completed in full and signed by both the patient and the healthcare provider.
- Only medication recommended in the AfA Clinical Guidelines will be considered for reimbursement. Please refer to these guidelines or contact AfA on **0800 22 7700**, or at **afa@afadm.co.za** for further information. Motivations will however always be considered. Please contact AfA for assistance if required.

I certify that the above particulars are - to the best of my knowledge and belief - true and accurate, having conducted a personal examination and procured the tests and/or other diagnostic investigations referred to. I confirm that I have counselled the patient on the importance of adhering to medication and performing the requested HIV monitoring tests. I acknowledge that the AfA programme will rely on such particulars when making any recommendations regarding payment for treatment to the relevant medical scheme. I acknowledge that telephonic discussions will be taped for medico-legal purposes.

Healthcare Provider Signature

Date D D M M Y Y Y Y

Medical Aid No ____ Dep Code ____

Patient Name