

AfA does not dispense medication - Please fax this completed form to **0800 600 773** or email it to **afa@afadm.co.za**

## Principal (Main) Member Details

First Name	<input type="text"/>	Surname	<input type="text"/>
Medical Scheme	<input type="text"/>	Gender	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Membership No.	<input type="text"/>	Option / Plan	<input type="text"/>

## Patient Details

First Name	<input type="text"/>	Surname	<input type="text"/>
Dependant Code	<input type="text"/>	Gender	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ID Number	<input type="text"/>	Date of Birth	<input type="text"/> 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

**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	<input type="text"/>		
Postal Address for confidential mail	<input type="text"/>		
Postal Code	<input type="text"/>	Telephone(Work)	<input type="text"/>
Fax	<input type="text"/>	Telephone(Home)	<input type="text"/>
Preferred form of communication	<input type="checkbox"/> EMAIL <input type="checkbox"/> FAX <input type="checkbox"/> POST	Cellphone	<input type="text"/>

## Doctor Details

Surname & Initials	<input type="text"/>	Practice No.	<input type="text"/>
Email Address	<input type="text"/>	Telephone	<input type="text"/>
Postal Address	<input type="text"/>		
Postal Code	<input type="text"/>	Cellphone	<input type="text"/>
Preferred form of communication	<input type="checkbox"/> EMAIL <input type="checkbox"/> FAX <input type="checkbox"/> POST	Fax	<input type="text"/>

## Details of HIV Exposure (i.e. rape or needle stick injury)

Nature of Incident	<input type="text"/>	Has Post-Exposure Treatment been started?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date of incident	<input type="text"/> 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	If YES, when	<input type="text"/>
Time of incident	<input type="text"/>		
Details of Source Patient or Perpetrator: (e.g. HIV Status)	<input type="text"/>	Details (e.g. starter pack)	<input type="text"/>
Has a Baseline HIV test been done on the patient?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Baseline HIV Result	<input type="text"/>

<b>Medication</b> - Note: Medication will be authorised for one month where indicated. Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated	<b>Dose</b> For child, please supply: Height = _____ Weight = _____
	<input type="text"/>
	<input type="text"/>

I understand that all personal clinical information supplied to the Aid for AIDS (AfA) programme will be used to determine access to specific benefits for the treatment of post exposure prophylaxis (PEP). 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 doctor, however, retains responsibility for your care, irrespective of the benefits so authorised.

I/we therefore, authorise any doctor, 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 familiarize 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 Aid for AIDS means that an AfA treatment support counsellor will contact me.

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

Patient's Signature	<input type="text"/>	Doctor's Signature	<input type="text"/>
			<input type="text"/> 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