MANAGED CARE DEPARTMENT
Tel: 3933810 / 3951166: Fax: 3935281 / 3951165
ART APPLICATION FORM – CONFIDENTIAL

IMPORTANT: Please note that all reasonable steps will be taken to maintain patient confidentiality

TO BE COMPLETED BY THE APPLICANT

PRINCIPAL MEMBER DETAILS:

Member's First name:	Surname:	Tittle: Mr / Mrs / Ms
Medical Scheme: **BPOMAS**	Option: **BPOMAS HIGH**	
Member's number:	I.D Number:	

PATIENT DETAILS:

First Name:	Surname:	Tittle: Mr / Mrs / Ms
I.D. Number:	Date of birth:	Beneficiary : Member /Spouse / Child
Telephone Number (H):	Telephone Number (W):	
Postal Address:		

To keep my correspondence confidential, post my letters to:

.....

.....

.....

OTHER DOCTOR(S) OR SPECIALIST(S) that you are seeing in addition to the doctor filling in this form.

Name of doctor	Specialty	Telephone	Fax

I/we understand that all personal clinical information supplied to the Managed Care Department (MCD) will be used, by the MCD's staff, to determine access to and make recommendations regarding the provision of specific benefits and relevant treatment plans. However, my / our doctor retains responsibility for my / our care, irrespective of the benefits authorised.

I/we authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependent (also new born baby), to provide the MCD with information that it may require.

I acknowledge that benefits authorised by the MCD are subject to the Medical Aid Scheme Rules.

I understand that acceptance onto the MCD means that I will be contacted by a MCD staff to assist me with the programme.

MEMBER'S SIGNATURE :.....

PATIENT'S SIGNATURE: Date: .....
(Not required if patient is a minor):.....

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DETAILS OF THE DOCTOR WHO WILL BE PROVIDING ONGOING CARE:

Doctor's surname:	First Name:	Med Aid Practice Number
Postal address:		
Telephone Number:	Fax Number:	
E-mail address:		

1. CLINICAL DATA

1.1 Weight :.....Kg and Height (if child):.....cm

1.2 When was HIV infection was first diagnosed?.....

1.3 Is the patient symptomatic Y N If Yes, state condition(s):.....

1.4 Gender Male Female If female is the patient pregnant? Y N

1.5 If pregnant, what is the expected date of delivery?:.....

1.6 Is the patient being treated for TB? Y N If yes, start date:.....

1.7 Has the patient previously been exposed to antiretrovirals? Y N If yes, please provide details in the next section.

Drugs	Duration (months)	Please insert code* for discontinuation reasons

*Discontinuation reason codes
A: cost
B: non-response
C: other – see below

Other reasons / adverse reactions:
.....
.....
.....

2 SPECIAL INVESTIGATION RESULTS:

2.1 **To prevent authorization of payment being delayed please always provide copies of reports.**

Investigations	Test done?		If yes, results	Dates performed DD/MM/YY
HIV serology	No	Yes	Positive	
CD4 count (% if child) (Latest report)	No	Yes	Cell/mm^3	
Viral load (Latest report)	No	Yes	Copies/ml	

2.2 Results of other important and relevant investigations done in the last year. **Copies of reports should be attached.**

Investigations	Test done?		If yes, results		Dates performed DD/MM/YY
Chest X-ray(s)	No	Yes			
Blood count (Hb) * - attach copy results	No	Yes			
Liver Function Tests** – attach copy results (transaminases)	No	Yes	AST(SGOT)	ALT (SGPT)	
Any other	No	Yes			

*Essential for approval of Zidovudine. ** Essential for Niverapine

3 CURRENT / PROPOSED DRUG REGIMEN (ARD ONLY - INCLUDE DOSAGE):

ANTIRETROVIRAL DRUGS and Directions for use	Period in use (if not Rx naïve: weeks, months)

4 OTHER DRUGS* (DRUGS USED / TO BE USED CONCURRENTLY WITH ARD – INCLUDING PCP & TB PROPHYLAXIS)

DIAGNOSIS	MEDICINE or DRUG and Directions for use	Period in use (weeks or months)	Period required (weeks or months)

*Generic equivalents will be approved unless otherwise contraindicated and / or stated.

This refers specifically to patient:..... .....
Surname First Name

DOCTOR'S SIGNATURE:..... Date:.....

Please fax completed form to: 3935 281 or 3951 165