primecure
healthcare management

HIV Disease Management Programme
Registration

Date: y y y y - m m - d d

A Designated service Provider Detail

Doctor: **Practice Number:** **Email:**

Tel: **Fax:** **Cell:**

B Patient Details

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

Surname: **Identity Number:**

First Name: **Medical Scheme:** **Option:**

Member Number: **Dep Code:**

C Previous HIV history

Date of Diagnosis (Year): y y y y - m m - d d

Previous HIV related illnesses/hospitalisations:

1. Year: y y y y 2. Year: y y y y

Other chronic ilnesses/hospitalisations:

1. ICD 10 Code Treatment Nappi Code:
2. ICD 10 Code Treatment Nappi Code:

D Clinical Assessment

Weight: kg **Height:** m

WHO Clinical Stage **Comments:**

HIV Pathology Results

CD 4 cell count **Date:** y y y y - m m - d d **Result:** /mm3

CD4% (Child < 12 years) **Date:** y y y y - m m - d d **Result:** %

VL **Date:** y y y y - m m - d d **Result:** copies/ml

RPR: **Hep B sAg** Pos: ◯ Neg: ◯

Other, specify

E Doctor Details

Doctor: **Practice Number:** **Email:**

Tel: **Fax:** **Cell:**

F Current Regime Requested

Doctor: **Doctor Signature:**

To be faxed with signed informed consent form, results and script to Prime Cure HIV Department: 0866 49 26 67 or email to: hivdmp@primecure.co.za

Kaelo Prime Cure (Pty) Ltd is a member of the Kaelo group of companies.
Kaelo Risk (Pty) Ltd is an authorised financial services Provider FSP: 36931,
underwritten by Centriq Insurance Company Limited FSP 3417.

kaelo

primecure
healthcare management

HIV Disease Management Programme
Patient Consent Form

EXPRESS VOLUNTARY INFORMED PATIENT CONSENT TO BE SIGNED BY THE PATIENT OR GUARDIAN IF PATIENT IS A MINOR. PREPARED IN ACCORDANCE WITH TH GUIDELINES PUBLISHED BY THE HPCSA AND THE NATIONAL PATIENTS RIGHTS CHARTER

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 that the purpose for doing pathology tests, i.e. ongoing monitoring 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 Programmeand 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.
- Shall be entitled to terminate my participation in the Programme at any time with immediate effect, but understand that the consequencesof 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 re-instate such benefits at any time thereafter.
- Acknowledge that should I not comply with the Programme protocols or prescribed treatment that the scheme, at its sole discretion, may elect to execise 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 the with clinical information pertaining to 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 noclinical 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 endeavors 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 unauthorized 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: y y y y - m m - d d

Full Names: _____

Surname: _____

Member Membership Number: _____

Identity Number: _____

AS WITNESS:

Name & Surname: _____ Signature: _____

Name & Surname: _____ Signature: _____

Kaelo Prime Cure (Pty) Ltd is a member of the Kaelo group of companies.
Kaelo Risk (Pty) Ltd is an authorised financial services Provider FSP: 36931,
underwritten by Centriq Insurance Company Limited FSP 3417.

kaelo