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HIV Disease Management Programme Registration

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

A Designated Service Provider Details:

Doctor: Practice Number: Email:

Tel: Fax: Cell:

B Patient Details:

Gender: Male ◯ Female ◯ Age Tel: Cell:

Surname:

First Name:

Member/Policy Number:

Medical Scheme/Health Insurer: Medical Scheme/Health Insurer Plan:

Identity 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

Address: 2nd Floor, The Oval - East Wing, Wanderers Office Park, 52 Corlett Drive, Illovo, 2196
Email: customerservice@primecure.co.za; Web: www.kaelo.co.za
Group Directors: J Jutzen
Non-Executive Directors: K Bouic, Z Omar
Reg. No. 1997 / 017429 / 07

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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/Health Insurer ("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 be limited to the statutory prescribed minimum benefits.
- Acknowledge that should I not comply with the Programme protocols or prescribed treatment that the Medical Scheme/Health Insurer, 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 Medical Scheme/Health Insurer 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 Medical Scheme/Health Insurer.

Signed at: _____ Date: y y y y - m m - d d

Full Names: _____

Surname: _____

Member/ Policyholder Signature: _____

Member Membership/Policy Number: _____

Identity Number: _____

AS WITNESS:

Name and Surname: _____ Signature: _____

Name and Surname: _____ Signature: _____

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