

Request for pre-exposure prophylaxis (PrEP)

Who we are

Bankmed (referred to as 'the Scheme'), registration number 1279, is a non-profit organisation, registered with the Council for Medical Schemes. Discovery Health (Pty) Ltd (referred to as 'the administrator') is a separate company and an authorised financial services provider (registration number 1997/013480/07) which takes care of the administration of your membership for the Scheme.

The preferred provider for GP consultations is the Premier Plus HIV GP Network.

How to complete this form

Step 1: Ensure the form is completed in full and signed by a Healthcare Professional

Step 2: Please return the completed form to us by e-mail to Hiv@bankmed.co.za

1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s (as per identity document)	<input type="text"/>		
Date of birth	<input type="text"/>	ID or passport number	<input type="text"/>
	<input type="text"/>		Gender <input type="text"/>
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
E-mail address	<input type="text"/>		
The outcome of this application must be sent to me by	<input type="checkbox"/> E-mail	<input type="checkbox"/> Fax	

Kindly ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details by logging into www.bankmed.co.za

Patient's signature (if patient is a minor, Principal Member must sign)	<input type="text"/>	Date	<input type="text"/>
	Original hand signature required		

2. Principal Member details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s (as per identity document)	<input type="text"/>		
Date of birth	<input type="text"/>	ID or passport number	<input type="text"/>
	<input type="text"/>		Gender <input type="text"/>
Membership number	<input type="text"/>		
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
E-mail address	<input type="text"/>		

Patient's signature (if patient is a minor, Principal Member must sign)	<input type="text"/>	Date	<input type="text"/>
	Original hand signature required		

3. Clinical data (to be completed by Healthcare Professional)

Expected treatment start date:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Expected duration of treatment:

Clinical reason for requesting PrEP:

Special investigation results (please provide copies of the reports):

	Test done?	If yes, specify results	Test date								
Baseline HIV test*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 300px;" type="text"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				
Serum Creatinine/eGFR	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 300px;" type="text"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y				

*Require a negative ELISA result < 1 month old before we will approve treatment.

4. Medication (to be completed by Healthcare Professional)

Diagnosis	Date when condition was first diagnosed	Medication name, strength and dosage	Number of repeats	How long has the patient used this medication?		May the patient use a generic medication?		
				Years	Months	Yes	No	Reason if no
HIV								
Opportunistic infections								

We will approve funding for generic medication where available, unless you have indicated otherwise

Kindly specify any other medication that the patient uses regularly

5. Healthcare Professional's details (to be completed by the Healthcare Professional)

Name

BHF practice number

--	--	--	--	--	--	--	--	--	--

Telephone

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Cellphone

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

E-mail

I acknowledge that the approval of this treatment is subject to the HIV status of the patient and that I have received the patient's consent to disclose their HIV status and any other related information to Bankmed Medical Scheme and Discovery Health (Pty) Ltd.

Signature of Healthcare Professional

Date

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Original hand signature required