Post-Exposure Prophylaxis
Application Form
Confidential

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		Surname	
Medical Scheme		Gender	MALE / FEMALE
Membership No.		Option / Plan	

Patient Details

First Name		Surname	
Dependant Code		Gender	MALE / FEMALE
ID Number		Date of Birth	D D M M Y Y Y 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			
Postal Address for confidential mail			
Postal Code		Telephone(Work)	
Fax		Telephone(Home)	
Preferred form of communication	EMAIL / FAX / POST	Cellphone	

Doctor Details

Surname & Initials		Practice No.	
Email Address		Telephone	
Postal Address			
Postal Code		Cellphone	
Preferred form of communication	EMAIL / FAX / POST	Fax	

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

Nature of Incident		Has Post-Exposure Treatment been started?	YES / NO
Date of incident	D D M M Y Y Y Y	If YES, when	
Time of incident			
Details of Source Patient or Perpetrator: (e.g. HIV Status)		Details (e.g. starter pack)	
Has a Baseline HIV test been done on the patient?	YES / NO	Baseline HIV Result	

Medication - Note: Medication will be authorised for one month where indicated. Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated	**Dose** For child, please supply: Height = _____ Weight = _____

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 tim . 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 _____ Doctor's Signature _____ D D M M Y Y Y Y