PRE-ART 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	

Clinical Details

When was HIV infection first diagnosed? (Please attach reports) D D M M Y Y Y Y

Has the patient previously been exposed to antiretrovirals? NO / YES - PMTCT / YES - PEP / YES - OTHER

If YES, please provide details

Is the patient allergic to any medication? Sulphonamides	YES / NO	Other allergies?	
Is there any other significant clinical finding?	YES / NO	If YES, specify	

Special Investigation Results

Date Test Performed (DD/MM/YYYY)	**CD4 count** (cells / mm)	**CD4%** (must be provided for children)	**Viral Load** (copies / ml)

Medication (If patient requires antiretrovirals, the 4 page application form must be completed)

Multivitamin supplement	YES / NO	Preferred Product Name	
TB prophylaxis (INH 300mg/day and Pyridoxine 25mg/day)	YES / NO	Period required (months)	

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 people with HIV infection. 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 time. 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 relevant to my HIV infection 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