ANTI RETRO VIRAL (ART) APPLICATION FORM

CONFIDENTIAL

Administered by Associated Fund Administrators Botswana (Pty) Ltd.
Gaborone: AFA House • Plot 61918 • P O Box 1212 • Gaborone • Botswana • Telephone: (+267) 365 0555 (Call center) / 365 0500 (Reception) • Fax: (+267) 395 1165
Francistown Branch: Plot 32397 • Office 26 Sunshine Plaza Francistown • P O Box 323 Francistown Botswana • Telephone : (+267) 241 2290 / 2390
www.pulamed.co.bw

MANAGED CARE DEPARTMENT: WhatsApp: +267 77091192 I **E-mail:** managedcaredepartment@afa.co.bw

IMPORTANT: Please note that all reasonable steps will be taken to maintain patient confidentiality

TO BE COMPLETED BY THE APPLICANT

PRINCIPAL MEMBER DETAILS:

Member's First name: Surname: Title: Mr ☐ Mrs ☐ Ms ☐

Medical Scheme: Option:

Member's number: I.D Number:

PATIENT DETAILS:

First Name: Surname: Title: Mr ☐ Mrs ☐ Ms ☐

I.D. Number: Date of birth:

Telephone Number (H): Telephone Number (W):

Postal Address: Beneficiary: Member ☐ Spouse ☐ Child ☐

To keep my correspondence confidential, post my letters to:

BUDDY DETAILS

Name of Buddy Telephone

Relationship Cellphone number

I/we understand that all personal clinical information supplied to the Managed Care Department (MCD) will be used, by the MCD's staff, to determine access to and make recommendations regarding the provision of specific benefits and relevant treatment plans. However, my / our doctor retains responsibility for my / our care, irrespective of the benefits authorised.

I/we authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependent (also new born baby), to provide the MCD with information that it may require.

I acknowledge that benefits authorised by the MCD are subject to the Medical Aid Scheme Rules.

I understand that acceptance onto the MCD means that I will be contacted by a MCD staff to assist me with the programme.

MEMBER'S SIGNATURE:

PATIENT'S SIGNATURE: Date:

(Not required if patient is a minor):

TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DETAILS OF THE DOCTOR WHO WILL BE PROVIDING ONGOING CARE:

Doctor's surname: First Name: Med Aid Practice Number

Postal address: Fax Number:

Telephone Number: E-mail address:

1. **CLINICAL DATA**

1.1 Weight: Kg and Height (if child): cm

1.2 When was HIV infection was first diagnosed?.

1.3 Is the patient symptomatic Y ☐ N ☐ If Yes, state condition(s):

1.4 Gender Male ☐ Female ☐ If female is the patient pregnant?

1.5 If pregnant, what is the expected date of delivery?:

1.6 Is the patient being treated for TB? Y ☐ N ☐ If yes, start date:

1.7 Has the patient previously been exposed to antiretrovirals? Y ☐ N ☐ If yes, please provide details in the next section.

Drugs	Duration (months)	Please insert code* for discontinuation reasons

*Discontinuation reason codes
A: cost
B: non-response
C: other – see below

Other reasons / adverse reactions:

2 **SPECIAL INVESTIGATION RESULTS:**

2.1 To prevent authorization of payment being delayed please always provide copies of reports.

Investigations	Test done?		If yes, results	Dates performed DD/MM/YY
HIV serology	No ☐	Yes ☐	Positive Negative	
CD4 count (% if child) (Latest report)	No ☐	Yes ☐	Cell/mm^3	
Viral load (Latest report)	No ☐	Yes ☐	Copies/ml	

2.2 Results of other important and relevant investigations done in the last year. Copies of reports should be attached.

Investigations	Test done?		If yes, results	Dates performed DD/MM/YY
Creatinine	No ☐	Yes ☐		
Chest X-rays	No ☐	Yes ☐		
Blood count (Hb) * attach copy results	No ☐	Yes ☐		
Liver Function Tests** – attach copy results (transaminases)	No ☐	Yes ☐	AST(SGOT) ALT(SGPT)	
Any other	No ☐	Yes ☐		

*Essential for approval of Zidovudine.
** Essential for Niverapine

3 CURRENT / PROPOSED DRUG REGIMEN (ARD ONLY - INCLUDE DOSAGE):

ANTIRETROVIRAL DRUGS and Directions for use	Period in use (if not Rx naïve: weeks, months)

4 OTHER DRUGS* (DRUGS USED / TO BE USED CONCURRENTLY WITH ARD – INCLUDING PCP & TB PROPHYLAXIS)

DIAGNOSIS	MEDICINE or DRUG and Directions for use	Period in use (weeks or months)	Period required (weeks or months)

*Generic equivalents will be approved unless otherwise contraindicated and / or stated.

This refers specifically to patient:

DOCTOR'S SIGNATURE: First Name Surname

Date:

Please fax completed form to: 3935 281