

Request for pre-exposure prophylaxis (PREP) 2021

Contact details

Tel: 0860 100 698 • PO Box 8012, Greenstone 1616 • www.malcormedicalaid.co.za

This application form is to register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for antiretroviral prophylaxis medicine is available subject to the Scheme Rules and the terms and conditions of the benefit.

This form is valid for 2021.

Who we are

The Malcor Medical Aid Scheme (referred to as 'the Scheme'), registration number 1547, 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). We take care of the administration of your membership for the Scheme.

How to complete this form

1. Please use one letter per block, complete in black ink and print clearly.
2. Please make sure the form is completed in full and signed by a healthcare professional.
3. Once complete, please email it to HIV_Diseasemanagement@malcormedicalaid.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"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D	ID or passport number	<input type="text"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		
How would you prefer to receive this letter?	Email <input type="checkbox"/>	Post <input type="checkbox"/>	

Please ensure your contact details are always up to date as we rely on this information to keep you updated. You may update your details on www.discovery.co.za

2. Main 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"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D	ID or passport number	<input type="text"/>
Sex	M <input type="checkbox"/> F <input type="checkbox"/>	Membership number	<input type="text"/>
Telephone (H)	<input type="text"/>	(W)	<input type="text"/>
Cellphone	<input type="text"/>	Fax	<input type="text"/>
Email address	<input type="text"/>		
Main member's signature	<input type="text"/>	Date	<input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D
Patient's name and surname	<input type="text"/>		
Membership number	<input type="text"/>		

MALRPP001

3. Clinical data (to be completed by doctor)

Expected treatment start date:

D	D	M	M	Y	Y	Y	Y
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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*	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input style="width: 250px;" type="text"/>	<table border="1" style="display: inline-table;"><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	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input style="width: 250px;" type="text"/>	<table border="1" style="display: inline-table;"><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. Medicine (to be completed by doctor)

Medicine	Dosage	Duration of treatment

Please specify any other medicine that the patient uses regularly

5. Doctor's details (to be completed by the doctor)

Name

BHF Practice number

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 Speciality

Telephone

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Cellphone

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Email

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 Malcor Medical Aid Scheme.

Signature of doctor

Date

Y	Y	Y	Y	M	M	D	D
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