Winner PMR Diamond Arrow Award

HAART ADULT APPLICATION

Strictly confidential

Please complete this form and return it to LifeSense. Thank you.

Once Completed, please

Email to: results@lifesense.co.za

Fax to: 0860 80 49 60

LifeSense Disease Management (PTY) LTD

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PO Box 1774
Parklands
2121
Fax: 0860 80 49 60
24 Hour call centre: 0860 50 60 80
www.lifesense.co.za

FOR OFFICE USE ONLY

REF. NO : _____ **CROSS REF. NO :** _____

IF ALL DATA MARKED WITH AN * IS NOT COMPLETED, THE APPLICATION WILL NOT BE PROCESSED
THIS APPLICATION MUST BE COMPLETED IRRESPECTIVE OF WHETHER THE MEMBER REQUIRES TREATMENT OR NOT

MAIN MEMBER DETAILS

MAIN MEMBER NAME: _____

GENDER: MALE ☐ FEMALE ☐ MAIN MEMBER ID NUMBER: _____

APPLICANT DETAILS

HAS THIS MEMBER BEEN WITH LIFESENSE BEFORE? YES ☐ NO ☐

SURNAME : _____

FIRST NAMES : _____

DATE OF BIRTH: ☐☐ ☐☐ ☐☐☐☐ GENDER: MALE ☐ FEMALE ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW (ER) ☐ COMMON LAW ☐

EMPLOYER DETAILS

EMPLOYER NAME: _____

JOB DESCRIPTION: _____

WORK PROVINCE: _____

TICK WHICH APPLICABLE: DAY SHIFT ☐ NIGHT SHIFT ☐

INCOME CATEGORY:

>R 10 000.00 / MONTH	☐	R 2 501 - R 4000.00 / MONTH	☐
R 6 001.00 - R 10 000.00 / MONTH	☐	R 1 501.00 - R 2 500.00 / MONTH	☐
R 4001.00 - R 6 000.00 / MONTH	☐	UNDER R 1 500.00 / MONTH	☐

MEDICAL AID DETAILS

MEDICAL AID : _____ MEDICAL AID NUMBER : _____

PLAN OPTION : _____ DEPENDENT CODE : _____

NEXT OF KIN DETAILS

NAME : _____

CONTACT NO. _____

RELATIONSHIP _____

continue overleaf

APPLICANT CONTACT DETAILS

Strictly confidential

PHYSICAL ADDRESS: _____

_____

_____

CODE: _____

POSTAL ADDRESS: _____

_____

CODE: _____

TELEPHONE NUMBER HOME: ( ) _____ CELLPHONE NUMBER: _____

TELEPHONE NUMBER WORK: ( ) _____ EMAIL ADDRESS: _____

DOCTOR'S DETAILS

PROOF OF IDENTIFICATION MUST BE SIGNED BY EXAMINER

I, THE EXAMINER acknowledge that I have counselled the applicant on the usage of the medication and should the applicant default in taking the medication, it could lead to multi-drug resistant virus and future treatment may not be available. Should the applicant refuse a equivalent, then he/she may be liable for a co-payment as per the schemes rules. I declare that I have taken due and proper care to verify the true identity of the applicant as stated above & have witnessed his/her signature.

NAME: _____

PRACTICE NUMBER: _____ QUALIFICATION: _____

ADDRESS: _____

_____

_____

CODE: _____

TELEPHONE NUMBER: _____ FAX NUMBER: _____

CELL NUMBER: _____ EMAIL ADDRESS: _____

DOCTOR SIGNATURE : _____ DATE: _____

THIS SECTION MUST PLEASE BE READ, UNDERSTOOD AND SIGNED BY THE APPLICANT & EXAMINER

Your participation in this programme is one of the most important ways to keep you well. For registration you will be required to answer medical questions, undergo a physical examination and have the following blood tests taken: FBC, CD4 count, HIV viral load test and should have these tests repeated every 16 weeks and only on request of the case manager. If you have any queries please do not hesitate to ask your doctor doing this examination about any of these tests. This process is essential to decide whether you need medication and which medication will be best for you. This application must be completed irrespective of whether the member requires medication or not.

The referral centre, LIFESENSE DISEASE MANAGEMENT & it's clients adhere to the rules of confidentiality as laid out by the Health Profession Council of South Africa. I, THE APPLICANT acknowledge that the examiner has explained the usage of the medication to me, if applicable. I, THE APPLICANT acknowledge that I am HIV positive and consent to the use of the appropriate HIV/AIDS medication prescribed by the treating service provider, if applicable. Should I not adhere to the prescribed medication, I understand that I will forfeit my HIV benefit immediately and be removed from the programme which could lead to my scheme membership being cancelled as per the scheme/employer rules. I the applicant acknowledge that I will be responsible for any co-payment that may be imposed.

I _____ understand that in order for the payment of services to the doctor or service provider, the medical aid fund will need to know my identity. I hereby consent to the above procedures. I agree that the medical information relevant to my HIV infection may be used for purposes of scientific, epidemiological and/or financial analysis without disclosure of my name and that LifeSense may send medical information to the treating doctor and medical aid if required.

MEDICATION DELIVERY ADDRESS

* DOCTOR'S ROOMS OR

POST OFFICE : _____

_____

_____

CODE: _____

continue overleaf

MEDICAL HISTORY

Strictly confidential

*** DATE FIRST SEROPOSITIVE (HIV positive):** _____

HAS THE APPLICANT EVER HAD ONE OR MORE AIDS DEFINING ILLNESSES? YES ☐ NO ☐

*** DOES PATIENT HAVE ANY DRUG ALLERGIES?** _____

*** Is the patient on any other medication at present? Please list:** _____

_____

WHAT IS THE STATUS OF YOUR PARTNER? POSITIVE ☐ NEGATIVE ☐ UNKNOWN ☐

IF POSITIVE IS YOUR PARTNER ON ARV'S? YES ☐ NO ☐

*** ANY CURRENT AND CHRONIC ILLNESSES HIV or NON HIV RELATED:**

_____

_____

*** HEIGHT cm:** _____ *** WEIGHT kg:** _____

TREATMENT DETAILS

*** PREVIOUS AND OR CURRENT TREATMENT FOR HIV.**

MEDICATION	FROM DATE	TO DATE

*** PLEASE LIST ANY TREATMENT REGIMEN SUGGESTED - OR GENERIC EQUIVALENT:**

_____

_____

SEROLOGICAL TESTS

URINE DIPSTICK: _____ *** PREGNANCY TEST** POSITIVE ☐ NEGATIVE ☐

LMP: _____ **EDD:** _____

DATE SEROLOGICAL TEST WAS DONE	
LABORATORY	
REQUISITION NUMBER	

TARRIF CODE	SEROLOGY TEST	RESULT	TARRIF CODE	SEROLOGY TEST	RESULT
3755	*** HB**				
3755	*** WCC**				
3797	*** PLATELETS**		**4171**	**Urea**	
3755	*** NEUTROPHILS**		**4032**	**Creatinine**	
3816	*** CD4 COUNT**				
3816	*** CD4%**				
4429	*** VIRAL LOAD**				

If the recommendation is accepted, a script will be generated and sent to the medicine distributor by the medical advisor.

ID NUMBER: _____

PLACE: _____

APPLICANT'S SIGNATURE : _____ DATE: _____