

Contact details

Tel: 0800 001 615 • PO Box 652509, Benmore, 2010 • www.engenmed.co.za

Request for pre-exposure prophylaxis (PREP)

Who we are

Engen Medical Benefit Fund (referred to as 'EMBF'), registration number 1572, is a non-profit organisation, registered with the Council for Medical Schemes.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, (referred to as 'the administrator') is a separate company, an authorised financial services provider and is responsible for the administration of your membership on behalf of the Fund.

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@engenmed.co.za

1. Patient details

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<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	<input type="text"/> _M <input type="text"/> _F		
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"/>		

The outcome of this application must be sent to me by Email Fax

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

2. Main member details (Please ONLY complete this section if the patient is a minor)

Title	<input type="text"/>	Surname	<input type="text"/>
First name/s	<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	<input type="text"/> _M <input type="text"/> _F		
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"/>		

Patient's signature
(if patient is a minor,
main member must sign)

Original hand signature required

Date _Y _Y _Y _Y _M _M _D _D

Patient's name and surname

Membership number

3. Clinical data (to be completed by doctor)

Expected treatment start date:

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*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>
Serum Creatinine/eGFR	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/>	<input type="text"/>

*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

Telephone

Cellphone

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 Engen Medical Benefit Fund and Discovery Health (Pty) Ltd.

Signature of doctor

Date