momentum

Health4Me Post-exposure prophylaxis (PEP) application form

Important notes:

- Please submit the completed and signed form via email to **health4mehiv@momentum.co.za**.
- For assistance call us on 0860 55 56 09.

1: Patient's details

Membership number

Member name

Member surname

Dependant code

Gender Male Female

ID number

Date of birth D D M M Y Y Y Y

Passport number

Passport country of origin

Contact number

Email address

2: Patient consent (to be signed by the member or guardian if the patient is a minor)

2.1 I hereby confirm that the information provided in this application is true and correct.

2.2 I acknowledge that Momentum Health Solutions (Pty) Ltd is the administrator of the HIV benefit programme and that any antiretroviral treatment prescribed, as well as the general management of my HIV condition, shall be the sole responsibility of my medical practitioners. Momentum Health Solutions (Pty) Ltd and my employer shall not be liable for any claims by me or my dependants arising from the implementation of the programme, where Momentum Health Solutions (Pty) Ltd was not negligent in executing its responsibilities.

2.3 I hereby give my consent to Momentum Health Solutions (Pty) Ltd and its staff to obtain my personal information (ie health and biometric) from my healthcare providers (medical doctor, pharmacy, pathology and radiology) to assess my medical risk and to enrol me on the programme, using such information to my benefit. I understand and agree that special personal information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological or financial analysis, without disclosure of my identity.

2.4 I understand that no information regarding my case will be made available to my employer or any other person not directly involved in my care.

2.5 Whilst Momentum Health Solutions (Pty) Ltd undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed, I am aware that Momentum Health Solutions (Pty) Ltd, my employer and healthcare providers shall also gain access to the same information.

2.6 I shall be entitled to terminate my participation in the programme at any time with immediate effect, but understand that the consequences of such a decision will rest with me alone.

2.7 I understand that calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the HIV benefit department.

2.8 I acknowledge that my details provided above are treated as confidential and I accept that the HIV benefit programme may use these contact details to communicate with me.

Member/guardian signature

Date D D M M Y Y Y Y

3: Doctor's details and consent

Practice number

Doctor's name

Doctor's surname

Telephone number

Email address

I confirm that the clinical details described in this document are, to my knowledge, accurate and correct. I understand the HIV benefit treatment protocols are guidelines only, and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's condition will reside with me. The reimbursement of therapy and related costs by Momentum Health Solutions (Pty) Ltd will be in accordance with the guidelines, as well as the benefit available to the above patient from time to time.

Doctor signature

Date D D M M Y Y Y Y

4: Details of exposure

Date of incident D D M M Y Y Y Y

Description of incident

Medication required

Please include a prescription for the medication recommended for treatment.

5: Serology result (done immediately post exposure)

HIV Elisa results

Date of test D D M M Y Y Y Y