



Contact details

Tel: 0860 123 007 • PO Box 652509, Benmore 2010 • www.tfgmedicalaidscheme.co.za

Request for pre-exposure prophylaxis (PREP)

This application form is to register for pre-exposure prophylaxis and to apply for antiretroviral prophylaxis medicine. Cover for prophylaxis antiretroviral medicine is available subject to the Scheme Rules and the terms and conditions of the benefit. This form is valid for 2020.

Who we are

TFG Medical Aid Scheme (referred to as 'the Scheme'), registration number 1578, 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. To avoid administration delays, please ensure this application is completed in full.
3. Once complete, please email it to HIV_Diseasemanagement@discovery.co.za

1. Patient details

Title Surname

First name/s

Date of birth ID or passport number

Sex M F Membership number

Telephone (H) (W)

Cell phone Fax

Email address

How would you prefer to receive this letter? Email Post

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 (Please ONLY complete this section if the patient is a minor)

Title Surname

First name/s

Date of birth ID or passport number

Sex M F Membership number

Telephone (H) (W)

Cell phone Fax

Email address

Patient's signature Date

(if patient is a minor, main member must sign)

Patient's name and surname

Membership number

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*	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 300px;" type="text"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"><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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input style="width: 300px;" type="text"/>	<table border="1" style="display: inline-table; border-collapse: collapse;"><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 name	Dosage	Duration	May the patient use generics		If no, reason
			Yes	No	

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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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 TFG Medical Aid Scheme and Discovery Health (Pty) Ltd.

Signature of doctor

Date

D	D	M	M	Y	Y	Y	Y
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Original hand signature required