

DOCTOR'S DETAILS AND CONSENT

Surname

Initials

Practice number

Provider discipline

Physical address

Postal code

Telephone numbers Work Cell phone

Fax

Email address

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

Doctor's signature _____

Date

DETAILS OF EXPOSURE

Type of incident: Sexual exposure Blood exposure

Date of incident

TREATMENT REQUESTED

MEDICATION	DOSE	MEDICATION	DOSE

PLEASE NOTE: Include a prescription for the medication recommended for treatment.

SEROLOGY RESULT: IMMEDIATELY DONE POST-EXPOSURE

HIV rapid test results _____

Date of test

HIV ELISA results _____

Date of test

Follow-up tests:

Please provide patient with lab request form for follow-up tests.

- HIV ELISA test to be repeated at six (6) weeks and three (3) months.
- FBC for an AZT regimen.

Membership no.

Patient name and surname