

# Application for GEMS HIV/AIDS Disease Management Programme

Registration for post-exposure prophylaxis



Date

## Section A: Patient details

Surname  First name   
 Gender M  F  ID no  Date of birth   
 Membership no  Dependant code  Option   
 Tel no (H) ()  (W) ()   
 Fax no ()  Cellphone no ()  (confidential)  
 Email (confidential)

Patient/guardian signature \_\_\_\_\_ Date

## Section B: Exposure

Is the exposure: Occupational  Non-occupational   
 Date of exposure:  Time:  :   
 What is the HIV status of the source? Known  Unknown  Delay <72 hours   
 Patient baseline HIV Test Negative

## Section C: Script

TREATMENT	STRENGTH	DIRECTION

## Section D: Designated practitioner details

Initials  Surname  Practice no   
 Tel no (H) ()  (W) ()   
 Fax no ()  Cellphone no ()  (confidential)  
 Email (confidential)

Doctor's signature \_\_\_\_\_ Date

Please fax the completed form to **0800 436 7329** or email to **hiv@gems.gov.za**