POST EXPOSURE PROPHYLAXIS CLAIM FORM

10 Mill Street, Newlands 7700 CAPE TOWN
P.O. Box 44991 Claremont, 7735
Tel: 0860 10 11 10
Fax: 0860 10 51 47
www.careworks.co.za

The following details should appear on your account:

1. To be completed by the DOCTOR / HOSPITAL

Authorisation No.	
Date	
Time of Consult	

Dr Last Name	
Initials & First Name	
Practice Number	
HPCSA Number	
Hospital Name	
Hospital Group	
Hospital Practice No.	
Telephone Number	(area code)
Fax Number	(area code)
Cell Number	
E-mail Address	
Physical Address	
Postal Address	(postal code)

Please complete all three information sheets:

1. **DOCTOR / HOSPITAL DETAILS;**
2. **PATIENT DETAILS; and**
3. **CLINICAL INFORMATION.**

Please ensure the correct signatures are included and dated.

Please fax these to CareWorks immediately to ensure patient follow-up:

CareWorks

P O Box 44991

Claremont 7735

Fax: 0860 10 51 47

2. To be completed by the PATIENT

PERSONAL DETAILS

Last Name		
First Name		
Initials		
Gender	MALE	FEMALE
ID Number		
Telephone No.	(area code)	
Cell No.		
E-mail Address		
Physical Address	(postal code)	

MEDICAL AID DETAILS

Medical Aid Name	
Medical Aid Option	
Medical Aid No.	
Main Member Initials	

EMPLOYER DETAILS

Name of Employer	
Employer Tel. No.	(area code)
Employer Address	(postal code)

MEDICATION DELIVERY (Important: If this changes please inform CareWorks 0860 10 11 10)

*Nearest Post Office where you can collect medication?	
#Confidential Phone No.	(area code)

*I, ……………………………………………… declare that the postal address above * and the phone number above # are confidential and that I can be sent communications with regard to medication delivery and dosage reminding without breach of confidentiality.*

Signature: ………………………………………………………… Date: ………………………………………………

3. CLINICAL INFORMATION

Patient ID No.: ______________________ Patient Name: ______________________

Scheme Name: ______________________ Member No.: ______________________

1. Assess the nature of exposure and tick the relevant boxes below.

☐ Intact Skin Exposure (No PEP) ☐ Mucosa ☐ Non-Intact Skin	☐ Solid needle ☐ Superficial wound	☐ Large bore needle ☐ Deep needle stick injury ☐ Visible blood on device causing injury ☐ Device used in vein or artery ☐ Unprotected receptive anal intercourse ☐ Unprotected receptive vaginal intercourse ☐ Unprotected insertive anal intercourse ☐ Unprotected insertive vaginal intercourse ☐ Unprotected receptive fellatio with ejaculation ☐ Rape

2. Perform 2 HIV Rapid tests as per instructions and record results: TEST 1: + - TEST 2: + - (circle)

3TC and AZT for 4 weeks	3TC and AZT for 4 weeks	3TC, AZT, Efavirenz or Nevirapine for 4 weeks

3. Is the patient pregnant? **YES** **NO** No Efavirerenz in 1st Trimester

4. Is HIV status of the source known? **YES** **NO** Awaiting source ELIZA result?

5. Has a confirmatory ELIZA test been requested? **YES** **NO**

Declaration by Doctor: I, Dr ……………………………………………… have informed the patient, ……………………………………………………………, that it is very important that s/he contacts CareWorks on 0860 10 11 10 for follow up medication and counselling. Dr signature: …………………………………………………Date……………………………