



HIV RISK MANAGEMENT APPLICATION FORM

Post Exposure Prophylaxis (PEP)

A. Important Information: (This Form Must be Completed by Members of NMC, BANKMED and PSEMAS.)

- PEP treatment is a once-off, and the application form is valid for that time only.
 - PEP benefits cover medications and HIV Rapid tests only.
 - The member is expected to maintain their health and should go for an HIV blood test 3 months after treatment to rule out the window period.
 - Counselling is critical. Thus, our counsellors will contact the member after the completion of the registration process.
 - Submit all relevant and correct information documents on time to avoid delays. Please complete all sections.*
 - Signing the forms indicates that you agree with the terms and conditions of the HIV clinical management programme.
 - Email completed forms and the prescription to wellness1@methealth.com.na.
- *The forms are subject to renewal after 12 months.

B. Patient's Personal and Clinical Details*

Surname

First Names

Gender M F Date of Birth Marital Status Single Married Divorced Child

Cell Phone Number City/Town

C. Medical Aid Details*

Medical Aid Fund: (Please tick the Correct Fund) NMC Bankmed PSEMAS Option:

Medical Aid Number: Membership Code:

D. Clinical Information*

Nature of Incident (Please tick the appropriate box) Rape Condom Burst Prick Unprotected sexual intercourse

Other, Specify

Date of Incident: Time of Incident:

HIV Rapid Testing Done Yes No If Yes, Results

Other Screenings Done: STIs HBV HSV Patient Previously Exposed to ART? Yes No

STIs Treated Yes No Emergency Contraceptive Provided Yes No

Regimen prescribed (Please tick the appropriate box based on the risk level):

High - Medium Risk: TDF300mg/3TC300mg/DTG50mg TAF 25mg//FTC200mg/ DTG50mg TLE400 (Avonza) TEE600

Low Risk: TDF300mg/FTC200mg or 3TC

*Rape cases should be provided with pregnancy emergency contraceptive pills, tetanus toxoid and STIs syndromic management based on the guidelines and level of infections.
 *Consult the MoHSS National ART guideline if children 10 years old and below weigh less than 20kg.

I confirm that the information provided in this application form is correct, and the patient comprehends all the information regarding the treatment.

Doctor's Full Names Practice Number

Doctor's Signature: Date