

Application for Registration on the Pharos HIV Programme

Membership Number

Date

Surname

First Name/s

Is this registration for yourself or a family member?

Myself

Family

Both

Please complete a separate form for each person in your family if applicable

When was HIV Diagnosed?

Are you on ARV's? (Tick block)

Y

N

Please provide us with your contact details in the spaces below so that we can keep in touch

Home Phone

code

Work Phone

code

ext

Department

Cell Phone (yours)

Cell Phone (alt)

e-mail Address

Postal Address
Where we can send you
information

Doctor's Name & Phone Number

May we contact your doctor directly for information?

Yes

No

Please sign here:

N.B. If you need medication to be registered, we must have your latest CD4 count and Viral Load (Blood test) results to do this. Please ask your doctor to send a copy of your latest prescription and your latest Blood tests to us.

ALL THE INFORMATION YOU GIVE US WILL BE KEPT STRICTLY CONFIDENTIAL AND WILL NOT BE SHARED WITH YOUR EMPLOYER OR ANYONE OTHER THAN YOUR DOCTORS AND PHARMACY WITHOUT YOUR PERMISSION.

Please return this form to Your Dedicated Professional Nurse or:

By e-mail to: phacare@pha.co.za or

By Fax to: 0866 067 035