| Client Medication Form | Bobby Goldsmith Foundation |
|---|---|

- *Only forms completed, signed & dated by a prescribing doctor or clinician will be accepted.*
- *This form provides confirmation of the HIV status of the client named below*
- *The client below has been prescribed valid Antiretroviral Medication as listed.*
- *Submitting this form does not guarantee eligibility for assistance with medication costs.*
- *All assistance is subject to BGF's annual caps.*
- ***Only medications listed on this form will be considered for financial assistance.***
- *If any medication on this form is changed, a new Client Medication Form is required.*

Client's Name _____ Date of Birth ____/____/____

| **Antiretroviral Medications** | |
|---|---|
| 1. | 2. |
| 3. | 4. |

***In addition to the list below, medications comprising a substance that is deemed addictive e.g. benzodiazepines, opiates etc. require a separate letter from the client's prescribing doctor justifying the prescription and its relationship with their underlying HIV condition.***

| **Other Medications** | **HIV-related Condition** |
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**Prescribing Doctor's Name**_____

Signature _____

Date ____/____/____

Surgery/ Clinic Stamp

I give consent for my medication details to be shared with Bobby Goldsmith Foundation

**Client Name** _____

Signature _____ Date ____/____/____