Cynllun Cynorthwyo Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

FORM C

APPLICATION TO JOIN THE PAYMENT SCHEME NEW HIV APPLICATIONS

SECTION 1(A) DATA PROTECTION AND APPLICANT'S DECLARATION

✓ Please tick to confirm

☐ **I understand** that data I provide may be shared with NHS service providers and Counter Fraud Services to ensure accurate and timely payment and for the purposes or prevention, detection and investigation of crime.

DECLARATION BY APPLICANT

I agree that the information I give on this form is complete and correct.

I agree to repay any money I receive to which it is found that I am no longer entitled.

I understand if I knowingly give wrong or incomplete information I may be prosecuted.

I have not received payment from any other UK scheme as a result of my HIV infection.

I agree to NHS Wales obtaining any data held on me by the Skipton Fund or the Caxton Foundation for the purposes of providing me with financial support.

I understand that NHS Wales may require to access data held on me by other public bodies and/or make any additional enquiries with other public bodies that may be necessary in order to reach a decision regarding my application.

Signature of Applicant		Date	

HOW WE USE YOUR INFORMATION

The personal information that you provide on this form will only be used by Velindre NHS Trust for the purposes of checking your eligibility for a payment and to administer your application. By submitting this form to a medical professional, you consent to your medical details requested in Sections 2 to 5 inclusive being supplied to Velindre NHS Trust for the purpose of administering your application.

In the event of a dispute as to your eligibility for payment, your information may be disclosed to the Appeals Panel. If your application is deemed to be ineligible, Velindre NHS Trust may keep your application form on file so that we have a full historical record in the event that you lodge an appeal or if you reapply for a payment at a later stage, in any event information we hold about you will be held for the purpose we collected it and kept for at least six years.

Your information will be held in the strictest confidence and will be kept securely, in accordance with the Data Protection Act 1998, and will not be shared with any other organisation. Velindre NHS Trust are a Data Controller under the Act in respect of the personal information which we collect about you. We have notified the Information Commissioner of our data processing activities and our registration number is Z5021900.

If you have any questions regarding the use of your information, or have any concerns with how your information is being processed, or wish to obtain a copy of information held by us about you, please contact us by writing to Velindre Cancer Centre, Velindre Road, Whitchurch, Cardiff, CF14 2TL

SECTION 1(B) APPLICANT DETAILS

Title		First Name	
Middle Name(s)		Surname	
Previous Names			
Address (this must be your main residence)			
		Post Code	
Home Telephone		Mobile Telephone	
E-Mail Address		Date of Birth	
NHS Number		National Insurance Number	

What is your marital status?

Tick One Option Below	✓
Married	
Civil Partnership	
Widowed	
Divorced	
Separated	
Single	
Living with Partner	

Have you ever applied to any of the UK schemes (e.g. MacFarlane Trust, Eileen Trust, MFET Limited) to receive payments with regards to your HIV infection?

Yes ☐ No ☐

If 'Yes', please advise what the outcome of your application was

SECTION 1(C) ADDITIONAL APPLICATION DETAILS

Do you believe you were infected with HIV as a result of treatment you received yourself with NHS blood, tissue, or blood products?

Yes ☐ No ☐

If 'Yes', please provide as much information as you can on how and when you believe this infection occurred

Alternatively, do you believe you were infected with HIV as a result of the virus being transmitted from someone else, who themselves were infected as a result of treatment with NHS blood, tissue, or blood products?

Yes ☐ No ☐

If 'No' this section is complete, if 'Yes' please provide further details below:

How do you believe the infection occurred?

Who do you believe you received this infection from?

Title		First Name	
Middle Name(s)		Surname	

Address

Post Code

What is/was your relationship to this person?

Have they ever registered with other UK support schemes?

Yes No Unknown

If known, please advise which scheme(s)

SECTION 1(D) ADDITIONAL INFORMATION

If you have any additional information you would like to provide, please add it here:

Once you have completed all parts of Section 1, please pass the form to a medical professional to complete.

The medical professional will complete the remainder of the form and return it directly to the Wales Infected Blood Support Scheme on your behalf.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY A MEDICAL

GUIDANCE NOTES FOR MEDICAL PROFESSIONALS

Thank you for your help with this application. In most cases this form will concern a patient who is known to you and who had been infected with HIV.

Sections 2-5 of this form should be completed in all cases. The purpose of these sections is:

- To confirm that the applicant had been infected with HIV

  And

- To confirm that the infection most probably arose through treatment with NHS blood, tissue or blood products

If there are questions in this form relating to the applicant that you cannot answer, please consult other medical professionals who have treated the applicant and who would be able to provide the information.

In some cases this form will concern a patient who had been indirectly by somebody who is (or was) infected themselves through NHS treatment.

When complete, please return this form along with all relevant documents direct to the following address:

Wales Infected Blood Support Scheme
Velindre Cancer Centre
Velindre Road
CF14 2TL

SECTION 2 (A) MEDICAL PROFESSIONAL'S DECLARATION

✓ Please tick to confirm

☐ **I understand** that data I provide may be shared with NHS Counter Fraud Services to ensure accurate payment and for the purposes of prevention, detection and investigation of crime.

DECLARATION BY MEDICAL PROFESSIONAL

I agree that the information I give in Sections 2-5 of this form is complete and correct.

I understand that if I knowingly give or endorse wrong or incomplete information this may result in disciplinary action and I may be prosecuted.

Signature of Medical Professional		Date	

SECTION 2 (B) DETAILS OF MEDICAL PROFESSIONAL COMPLETING FORM

Registered Medical Practitioner's GMC registration number (if practising in UK)

In what capacity have you completed this form? (E.g. GP, consultant, etc.)

How long have you known the person in respect of whom you have completed this form? Years Months

Your Details

Title First Name

Middle Name(s) Surname

Hospital/Surgery Address

Post Code

Telephone E-Mail Address

If you consulted any other medical professional(s) to help you complete this form, please provide their details here:

SECTION 3 (A) TO CONFIRM THE APPLICANT'S ELIGIBILITY FOR PAYMENT

Are there any records to suggest the applicant has previously applied to another UK scheme (e.g. MacFarlane Trust, Eileen Trust, MFET Limited) to receive payments with regards to their HIV infection?

Yes ☐ No ☐

If 'Yes', please provide details below.

Has the applicant tested positive for HIV? Yes ☐ No ☐

If 'Yes', what was the date of first diagnosis? ☐

PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING ALL OF THE ANSWERS IN SECTION 3(A)

SECTION 3 (B)	TO CONFIRM WHETHER INFECTION AROSE INDIRECTLY

In your opinion, is it probable the applicant was infected as a result of transmission of the virus from another person who had themselves been infected through treatment with NHS blood, blood products, or tissue?

Yes ☐ No ☐

If 'Yes', did transmission occur as a consequence of:

- Sexual intercourse? Yes ☐ No ☐
- Accidental needle stick? Yes ☐ No ☐
- Mother-to-baby transmission? Yes ☐ No ☐
- Other? (please specify) Yes ☐ No ☐

PLEASE PROVIDE DETAILS AND A COPY OF TEST RESULTS

If any of the answers in Section 3(B) are 'Yes', please go to Section 5(B)

SECTION 4 — TO BE COMPLETED ONLY IN RESPECT OF INFECTED PEOPLE WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS

Does the applicant have, or is a carrier of, an inherited or acquired bleeding disorder? (E.g. Haemophilia or Von Willebrand disease) Yes ☐ No ☐

Were any of the following used to treat the applicant before September 1991?

- Whole blood or components (Including platelets, red cells, neutrofils etc.) Yes ☐ No ☐
- Cryoprecipitate Yes ☐ No ☐
- Plasma/FFP Yes ☐ No ☐

Were any of the following used to treat the applicant before September 1991?

- Factor VIII concentrate Yes ☐ ☐
- Factor IX concentrate Yes ☐ ☐
- FEIBA Yes ☐ ☐
- DEFIX Yes ☐ ☐
- Fibrinogen Yes ☐ ☐
- Other coagulation factor concentrate Yes ☐ ☐

If other coagulation factor concentrate, which?

Did any of the above treatments include repeated doses? Yes ☐ No ☐

Please indicate volumes used for each product.

In which NHS hospital(s) did the applicant receive the products listed before September 1991?

If none of the products listed above were used to treat the applicant before September 1991, do you think it is probable that the applicant's HIV infection was caused through treatment with NHS blood or blood products received before then?

Yes ☐ No ☐

If 'Yes', please provide details

PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING THE ANSWERS PROVIDED IN SECTION 4

If Section 4 has been completed and the applicant's source of infection is likely to have been a blood transfusion(s), rather than blood products, please complete Section 5(A)

Otherwise, if Section 4 has been completed, please go straight to Section 5(B)

SECTION 5 (A) TO CONFIRM THAT INFECTION MOST PROBABLY AROSE THROUGH NHS TREATMENT

On which date is it believed that infection (e.g. via a blood transfusion) occurred?

In what NHS hospital or other facility is it believed infection occurred? (If the applicant had more than one blood transfusion or tissue transplant please list all the hospitals or facilities where they took place)

Please specify under what circumstances is it believed that infection occurred? (e.g. during surgical procedures, A&E treatment, etc.)

Do any records exist of the possible occasion(s) of infection and of any symptoms of infection? Yes ☐ No ☐

If 'Yes', please specify and enclose a copy of the relevant records.

Were any of the following used to treat the applicant before September 1991?

- Albumin — Yes ☐ No ☐
- Intravenous immunoglobulin — Yes ☐ No ☐
- Plasma/FFP — Yes ☐ No ☐
- Bone marrow — Yes ☐ No ☐
- Whole blood or components (including platelets, red cells, neutrofils etc.) — Yes ☐ No ☐

If so, for what purpose and did the treatment involve repeated doses? (Please indicate volumes used for each product)

Does any evidence exist of any other possible source of infection? (E.g. treatment with other blood products or tissue, etc.) Yes ☐ No ☐

If 'Yes', please specify

If the date of infection cannot be proved, do you think it is probable that infection occurred before September 1991? Yes ☐ No ☐

If 'Yes', please specify

SECTION 5 (B) OTHER POSSIBLE SOURCES OF INFECTION

Based on evidence or your experience, has the applicant ever been treated for, or been involved with injecting drug use? (This could include living with, or being in a sexual relationship with, a person who injects or injected drugs)

Yes ☐ No ☐

If 'Yes', please provide further details

Has the applicant ever received hospital treatment outside the UK? Yes ☐ No ☐

If 'Yes', please confirm what treatment, where and when?

Is there any other evidence that might affect the eligibility of the applicant for payment. (E.G being in a sexual relationship with people in a group with high HIV prevalence, or from countries with high HIV prevalence)? Yes ☐ No ☐

If 'Yes', please specify

In your opinion, is it probable that the applicant's HIV infection was acquired as a consequence of NHS treatment received before September 1991?

Yes ☐ No ☐

If ‘No’, please give your reasons

Thank you for completing this form. The form and all supporting documents must be sent directly to the Wales Infected Blood Support Scheme at:

Wales Infected Blood Support Scheme
Velindre Cancer Centre
Velindre Road
Whitchurch
Cardiff CF14 2TL