



The HIV programme does not dispense medication - Please fax this completed form to 0800 600 773 or email it to polmedhiv@medscheme.co.za

This SECTION needs to be completed by - THE APPLICANT | Applications will be rejected unless signed by both Applicant and Doctor

### Principal (Main) Member Details

First Name \_\_\_\_\_ Surname \_\_\_\_\_  
 Medical Scheme \_\_\_\_\_ Gender    
 Membership No. \_\_\_\_\_ Option/Plan \_\_\_\_\_

### Patient Details

First Name \_\_\_\_\_ Surname \_\_\_\_\_  
 Dependent Code \_\_\_\_\_ Gender    
 ID Number                    Date of birth

**Treatment Support is a vital part of the HIV programme. Contact details must be supplied to enable us to provide you with this support.**

Confidential Email \_\_\_\_\_  
 Postal Address for Confidential Mail \_\_\_\_\_  
 Postal Code \_\_\_\_\_ Telephone (Work) \_\_\_\_\_  
 Fax \_\_\_\_\_ Telephone (Home) \_\_\_\_\_  
 Preferred form of Communication    Cellphone \_\_\_\_\_  
 First Language \_\_\_\_\_  
 What time of Day do you wish to be Contacted   Second Language \_\_\_\_\_

### Next of kin or trusted friend who can be contacted if we cannot reach you (should know your HIV status)

First Name \_\_\_\_\_ Telephone (Home) \_\_\_\_\_  
 Surname \_\_\_\_\_ Telephone (Work) \_\_\_\_\_  
 Cellphone \_\_\_\_\_

I understand that all personal clinical information supplied to the HIV programme will be used to determine access to specific benefits for people with HIV infection. HIV programme will take all reasonable steps to maintain confidentiality. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. Your doctor, however, retains responsibility for your care, irrespective of the benefits so authorised. I/we therefore, authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependant (also newly born baby), to provide the HIV programme with information that it may require. I warrant that the information in this application form is correct. I acknowledge that completion of the application form does not automatically entitle me to any benefits and that acceptance to the programme is within the sole discretion of the HIV programme. I acknowledge that I am familiar with the conditions and benefits of the programme, notwithstanding representation by any other party; and agree to abide by and undertake to familiarize myself with the rules of the programme as amended from time to time. I acknowledge that benefits authorised by the HIV programme are subject to scheme rules and that non adherence to the programme could result in my benefits from this programme being cancelled. I acknowledge that I will be responsible for any co-payments as per scheme rules or payment for any medication and/or investigations not authorised by the HIV programme. I understand that acceptance onto the HIV programme means that an HIV treatment support counsellor will contact me. I herewith authorise the HIV programme and its agents/medical staff to disclose the medical information relevant to my HIV infection to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

Patient's signature \_\_\_\_\_ Date



This SECTION needs to be completed by - THE DOCTOR

**Doctor Details**

Surname & Initials \_\_\_\_\_ Practice No. \_\_\_\_\_  
 Email Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 Postal Address \_\_\_\_\_  
 Postal Code \_\_\_\_\_ Cellphone \_\_\_\_\_  
 Preferred form of Communication:    Fax \_\_\_\_\_

**Clinical History**

**When was HIV infection first diagnosed? (Please attach reports)**

Type of Screening Test \_\_\_\_\_ Test Date   
 Type of Confirmatory Test \_\_\_\_\_ Test Date   
 Is the patient currently being treated for Tuberculosis?   If YES, specify start date   
 Has the patient previously been exposed to antiretrovirals?

If YES, please provide details - Note: If the application is for a baby please list mom's previous ART history.

Drugs	Start Date	End Date	Duration (Months)	Reason for Discontinuation

Current combination patient is taking \_\_\_\_\_ Start Date   
 Please list all other medication the patient is taking, including prophylaxis \_\_\_\_\_  
 Is the patient allergic to any medication? Sulphonamides   Other Allergies   If YES, specify \_\_\_\_\_

**Information required to prevent adverse side-effects of certain drugs**

Current heavy alcohol intake? (i.e. more than 4 drinks per day for a long period of time)    
 Current recreational drug use? (Cannabis, Cocaine, Ecstasy, LSD etc.)    
 Current depression or psychiatric illness?    
 If YES, specify treatment \_\_\_\_\_  
 Current use of traditional or herbal remedies?



### Clinical Examination

Weight  kg  
Height  cm

WHO Clinical Staging  1  2  3  4

Please tick disease below if Stage 3 or 4

Pregnant  YES  NO

If YES, specify

Expected date of delivery  D  D  M  M  Y  Y  Y  Y

Expected mode of delivery  NVD  C/S

Expected date of C/S  D  D  M  M  Y  Y  Y  Y

#### Clinical Stage 3 - Adult / Adolescent

- Unexplained severe weight loss (>10% of body weight)
- Unexplained chronic diarrhoea > one month
- Unexplained persistent fever > one month
- Persistent oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis
- Severe bacterial infections (e.g. pneumonia)
- Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis
- Unexplained anaemia, neutropaenia, chronic thrombocytopenia

#### Clinical Stage 3 - Paediatric

- Unexplained moderate malnutrition
- Unexplained persistent diarrhoea (14 days or more)
- Unexplained persistent fever > one month
- Persistent oral candidiasis (after first 6 weeks of life)
- Oral hairy leukoplakia
- Acute necrotizing ulcerative gingivitis / periodontitis
- Lymph node TB
- Pulmonary TB
- Severe recurrent bacterial pneumonia
- Symptomatic lymphoid interstitial pneumonitis
- Chronic HIV-associated lung disease including bronchiectasis
- Unexplained anaemia, neutropaenia, chronic thrombocytopenia

#### Clinical Stage 4 - Adult / Adolescent / Paediatric

- HIV wasting syndrome (See Clinical Guidelines for definitions)
- Pneumocystis pneumonia
- Recurrent severe bacterial pneumonia
- Chronic herpes simplex infection
- Oesophageal candidiasis
- Extrapulmonary tuberculosis
- Kaposi's sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy
- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculous mycobacterial infection
- Progressive multifocal leukoencephalopathy
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated mycosis
- Recurrent septicaemia (including non-typhoidal Salmonella)
- Lymphoma (cerebral or B-cell non-Hodgkin)
- Invasive cervical carcinoma
- Atypical disseminated leishmaniasis
- Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy

Is there any degree of peripheral neuropathy?  YES  NO Is there any degree of peripheral neuropathy?  Mild  Moderate  Severe

Is there any other significant clinical finding?  YES  NO If YES, please specify \_\_\_\_\_



### Special Investigation Results (Please provide copies of reports. Supply as many results as possible, including baseline results)

Date Test Performed D D M M Y Y Y Y	CD4 count (cells / mm)	CD4% (must be provided for children)	Viral Load (copies / ml)

Additional Investigations	Test Done	If YES, specify results	Test Date
Blood count(s) <small>(Essential prior to approval of Zidovudine)</small>	YES NO		D D M M Y Y Y Y
Baseline ALT <small>(Essential prior to approval of Nevirapine)</small>	YES NO		D D M M Y Y Y Y
Serum creatinine/eGFR <small>(Essential for patients with renal failure or prior to approval of Tenofovir)</small>	YES NO		D D M M Y Y Y Y

### Medication (Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated)

Antiretroviral Therapy	Strength (e.g. 10 mg)	Directions (e.g. 1 tds)	Period in Use (months)	Period Required (months)

### Other Medication Required (Associated with the management of HIV)

Diagnosis	Medicines	Strength (e.g. 10 mg)	Directions (e.g. 1 tds)	Period in Use (months)	Period Required (months)

### Acknowledgement by Examining Doctor

**Please Note:**

- Tariff code 0199 will only be paid for the first time completion of the application form. The form must be completed in full and signed by both the patient and the doctor.
- Approval for ongoing antiretroviral therapy will only be considered if the result and date of a recent CD4 count and viral load is supplied. Only medication recommended in the HIV Clinical Guidelines will be considered for reimbursement. Please refer to these guidelines or contact the HIV programme on 0800 22 7700, or at polmedhiv@medscheme.co.za for further information. Motivations will however always be considered. Please contact the HIV programme for assistance if required.

I certify that the above particulars are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and procured the tests and/or other diagnostic investigations referred to. I confirm that I have counselled the patient on the importance of adhering to medication and monitoring test regimens. I acknowledge that the HIV programme will rely on such particulars when making any recommendations regarding payment for treatment to the relevant medical scheme. I acknowledge that telephonic discussions will be taped for medico-legal purposes.

Doctor's signature \_\_\_\_\_

Date D D M M Y Y Y Y