

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 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	

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	

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