PLATINUM
HEALTH

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HIV MANAGEMENT PROGRAMME APPLICATION FORM

1. Please complete the HIV management programme application form in PRINT with black ink and forward to Platinum Health.
2. Relevant test results must be attached.
3. Failure to provide all information, will result in unnecessary delays.

1 PATIENT INFORMATION (Please complete in full)

Platinum Health membership number: | | | | | | | | | | | Patient dependant code: | |

Title: Prof | Dr | Mr | Ms Initials: Surname:

Names in full (as per identity document):

Date of birth: C C Y Y M M D D E-mail:

Tel no (Home): Tel no (Work): Cell no:

Sex: Male | Female The outcome of this application must be communicated to me via Email | SMS

Other doctors or specialists (that you are seeing in addition to the doctor filling in this form):

Name:

Tel no (Practice): Speciality:

2 DECLARATION

I hereby apply for the HIV DISEASE MANAGEMENT PROGRAMME and agree that I will be bound by the Rules of the Scheme as amended from time to time. I warrant that the information in this application is complete and correct. I understand that all personal clinical information supplied to Platinum Health will be used to determine access to specific benefits regarding the HIV DISEASE MANAGEMENT PROGRAMME. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. I understand that acceptance onto the HIV DISEASE MANAGEMENT PROGRAMME means that a treatment support counsellor will contact me.

Patient signature: Parent/Guardian signature: (If the patient is a minor, parent, legal guardian or custodian must sign the form.)

Date: C C Y Y M M D D

Please complete and send to 086 577 0274

3 DOCTOR WHO WILL PROVIDE ONGOING CARE (to be completed by the doctor)

Name:

Date: C C Y Y M M D D Speciality:

Tel no (Home): Fax no: E-mail:

Qualifying degree: BHF Practice number:

HPCSA/MP number:

4 CLINICAL HISTORY (current diagnosis and medication recorded under section 6)

When was HIV infection first diagnosed? (Please attach report): C C Y Y M M D D

Is the patient currently being treated for tuberculosis? Yes No

If YES, please specify the treatment start date: C C Y Y M M D D

Has the patient previously been exposed to antiretrovirals? Yes (MTCT prophylaxis) Yes (other) No

If YES, please provide details below:

PREVIOUS ANTIRETROVIRAL EXPOSURE NOTE: IF THE APPLICATION IS FOR A BABY, PLEASE LIST THE MOTHER'S PREVIOUS ART HISTORY.

DRUGS	DATE TREATMENT STARTED	DATE TREATMENT ENDED	TREATMENT DURATION (MONTHS)	REASON FOR DISCONTINUATION

Current combination the patient is taking:

Please list all other medication the patient is taking, including prophylaxis:

Is the patient allergic to any medication? Yes No Is the patient allergic to sulphonamides? Yes No

Does the patient have any other allergies? Yes No If YES, please specify:

Is there a history of depression or psychiatric illness? Yes No

If YES, please specify treatment:

Is there a history of heavy alcohol intake? (More than four drinks per day for a long period of time) Yes No

Is there a history of recreational drug use? (Cannabis, Cocaine, Ecstasy, LSD etc.) Yes No

Platinum Health membership number:

Patient name and surname:

Please complete and send to 086 577 0274

5 CLINICAL EXAMINATION (to be completed by the doctor)

Female patients

Is the patient pregnant? Yes | No **If YES, expected date of delivery:** C C Y Y M M D D

Expected mode of delivery: NVD | C/S **Expected date of C/S:** C C Y Y M M D D

Please specify in Section 6 whether I/V or oral medicines are preferred during labour.

Patient weight in kilogram: **Patient height in metres:**

WHO CLINICAL STAGING:
Adult / Adolescent

Clinical stage 1: (Please tick)

- Generalised lymphadenopathy

Clinical stage 2: (Please tick)

- Weight loss, <10% of body weight
- Shingles within the last five years
- Recurrent upper respiratory tract infections

Clinical stage 3: (Please tick)

- Weight loss (= kg), >10% of body weight
- Unexplained chronic diarrhoea >1 month
- Oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis
- Severe bacterial infections (i.e. pneumonia)

Clinical stage 4: (Please tick)

- HIV wasting syndrome
- AIDS defining opportunistic infection. Please specify:

Paediatric

Clinical stage 1: (Please tick)

- Generalised lymphadenopathy

Clinical stage 2: (Please tick)

- Unexplained chronic diarrhoea
- Recurrent severe bacterial infections
- Persistent Fever
- Weight loss or failure to thrive
- Severe persistent or recurrent candidiasis outside the neonatal period

Clinical stage 3: (Please tick)

- Severe failure to thrive
- Progressive encephalopathy
- Recurrent septicaemia or meningitis
- Malignancy
- AIDS defining opportunistic infection. Please specify:

Is there any degree of peripheral neuropathy? **If YES, please specify:**

Is there any other significant clinical finding? **If YES, please specify:**

Platinum Health membership number:

Patient name and surname:

Please complete and send to 086 577 0274

6 SPECIAL INVESTIGATIONS RESULTS (provide copies of all reports and as many as possible)

DATE THAT TEST WAS PERFORMED	VIRAL LOAD (copies / ml)

ADDITIONAL INVESTIGATIONS	WERE TESTS PERFORMED?		IF YES, PLEASE SPECIFY THE RESULTS	DATE TESTS WERE PERFORMED
Haemoglobin	YES	NO		
U & E	YES	NO		
ALT	YES	NO		
Cholesterol (Total)	YES	NO		
Tuberculin skin test (TST)	YES	NO		

7 MEDICATION

NOTE TO MEMBER AND DOCTOR: PLEASE NOTE THAT GENERIC EQUIVALENTS WILL BE DISPENSED AS PER FORMULARY.

ANTIRETROVIRAL THERAPY	STRENGTH (e.g. 10mg)	DIRECTIONS (e.g. 1 tds)	PERIOD IN USE (MONTHS)	PERIOD REQUIRED (MONTHS)

Other Medication Required (associated with the management of HIV)

DESCRIPTION OF DIAGNOSIS	DATE OF FIRST DIAGNOSIS	MEDICATION NAME, STRENGTH AND DOSAGE	HOW LONG HAS THE PATIENT USED THIS MEDICATION?		MAY A GENERIC BE USED?	
			YEARS	MONTHS	YES	NO

8 DOCTOR'S DETAILS AND SIGNATURE (to be completed by the doctor)

Name:

Date: C C Y Y M M D D Speciality:

Tel no (Practice): Doctor's signature:

Platinum Health membership number:

Patient name and surname:

Please complete and send to 086 577 0274

9 SOCIAL WORKER ASSESSMENT

10 PSYCHOLOGIST ASSESSMENT

Platinum Health membership number:

Patient name and surname:

Please complete and send to 086 577 0274

11 DECLARATION BY PATIENT

1. I understand that the information contained in this application for enrolment in Platinum Health's HIV Programme will be treated with complete confidentiality and sensitivity. I also understand that although every care is taken to keep my HIV status completely confidential, Platinum Health has no control over any conclusions my dependants may draw regarding my HIV status during the normal claims process.

2. I understand that Platinum Health needs to access my personal clinical information to make recommendations regarding my chronic medication needs and to provide me with the full benefits of the Platinum Health HIV Programme. I therefore authorize any third party, disease management, previous scheme or health care professional e.g. pathology, laboratories, doctors, hospitals, etc, in possession of any medical information regarding my dependants (if minor) or myself, to provide Platinum Health with any information, that they may require, with the exception of any information that I stipulate in writing may not be provided to Platinum Health. I acknowledge that my medical service provider retains responsibility for my diagnosis and treatment.

3. I am aware that I am HIV-positive.

4. I understand that, at this stage, HIV infection can be treated with antiretroviral therapy, but that there is no cure available as yet.

5. I understand that if I am eligible for antiretroviral therapy, I will be required to take all the medication prescribed to me as directed and that I cannot skip doses of my medication. If I should require assistance with taking my medication or find that the medication makes me unwell, I will know that I can contact my medical practitioner and/or Platinum Health to assist me.

6. Cover for ART is subject to national antiretroviral treatment guidelines, clinical entry criteria and pre-authorisation.

7. I understand that once I have registered on the programme, there will be no limit on HIV-related hospital admissions, subject to my option type and sub-limits. However, if I don't comply with the Platinum Health HIV Programme, I acknowledge that Platinum Health reserves the right to review my further participation in the programme. If my participation on the programme is terminated as a result of my failure to comply with the programme, my entitlement to such benefits may be reviewed.

8. I consent to Platinum Health disclosing to such pharmacies and contracted providers of disease management programmes such information of mine as is necessary to ensure that I receive the full benefits of the Platinum Health HIV Programme. I understand that such pharmacies and providers are bound by obligations of confidentiality.

9. I understand that Platinum Health will facilitate admissions to the most appropriate facility in consultation with me and my treating doctor.

10. I understand the consequences of not taking ART as it has been explained to me. I understand I have a right to decline or accept ART.

ACCEPT OR DECLINE (please mark with a X)

Patient signature: _____ Parent/Guardian signature: _____ (If the patient is a minor, parent, legal guardian or custodian must sign the form.)

Date: C C Y Y M M D D

Platinum Health membership number: _____

Patient name and surname: _____

Please complete and send to 086 577 0274