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Aid for AIDS Programme

APPLICATION FORM – CONFIDENTIAL

NB: APPLICATIONS WILL BE REJECTED UNLESS SIGNED BY BOTH APPLICANT AND DOCTOR

FIRST PAGE – TO BE COMPLETED BY APPLICANT

PRINCIPAL (MAIN) MEMBER DETAILS

Member's first name:		Surname:			
Medical Scheme:		Gender:		MALE	FEMALE
Membership number:		Option/Plan:			

PATIENT DETAILS

Patient's Surname:		Dependant Code:									
First Name:		Gender:						MALE		FEMALE	
ID number:		Date of Birth:	D	D	M	M	Y	Y	Y	Y	
Postal address of choice for **confidential** mail:											
								Postal Code:			

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

Telephone numbers:	HOME:	CODE		WORK:	CODE		FAX:	CODE	
Cellphone:				E-mail: (please print)					
What time of day is the best time for AfA to contact you?	MORNING		AFTERNOON						
What is your first language?				What is your second language?					

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

Name of Next of Kin/Buddy	Surname:			First Name:					
Telephone numbers:	HOME:	CODE		WORK:	CODE		CELLPHONE:		

I understand that all personal clinical information supplied to the Aid for AIDS (AfA) programme will be used to determine access to specific benefits for people with HIV infection. AfA 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 AfA 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 AfA. 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 AfA 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 authorized by AfA.

I understand that acceptance onto Aid for AIDS means that an AfA treatment support counsellor will contact me.

I herewith authorize AfA 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:		D	D	M	M	Y	Y	Y	Y
		DATE							

Medical Aid Number:_____ Dependent Code:_____ Patient Name:_____

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PAGES 2 – 4: TO BE COMPLETED BY THE ATTENDING MEDICAL PRACTITIONER

DETAILS OF THE DOCTOR WHO WILL BE PROVIDING ONGOING CARE:

Doctor's Surname:		Initials:		Qualifying Degree:	
Practice Number:		Registration Number:		E-mail address:	
Postal Address:				Postal Code:	
Physical Address:				Postal Code:	
Telephone Numbers:	CODE		Fax NO: CODE		Cellphone:

1. CLINICAL HISTORY (Current diagnosis and medication recorded under Point 4.)

1.1	When was HIV infection first diagnosed? (Please attach reports.)	Type of screening test:	D	D	M	M	Y	Y	Y	Y
		Type of confirmatory test:	D	D	M	M	Y	Y	Y	Y
1.2	Is the patient currently being treated for tuberculosis?	YES	NO	If Yes, start date?	D	D	M	M	Y	Y	Y	Y
1.3	Has the patient previously been exposed to antiretrovirals?	YES – MTCT prophylaxis	YES - Other	NO								
1.4	If 1.3 is YES, provide details of previous antiretroviral exposure *Note: If the application is for a baby please list mom's previous ART history.*											

Drugs	Date Treatment Started	Date Treatment Ended	Duration (months)	Reason for discontinuation

1.5	Current combination patient is taking:		Date started:	D	D	M	M	Y	Y	Y	Y
1.6	Please list all other medication the patient is taking, including prophylaxis:														
1.7	Is the patient allergic to any medication?	Sulphonamides?	YES	NO	Other allergies?	YES	NO	Please Specify:							

INFORMATION REQUIRED TO PREVENT ADVERSE SIDE-EFFECTS OF CERTAIN DRUGS:

1.8	Current heavy alcohol intake? (i.e. more than 4 drinks per day for a long period of time)	YES	NO
1.9	Current recreational drug use? (Cannabis, Cocaine, Ecstasy, LSD etc.)	YES	NO
1.10	Current depression or psychiatric illness? If yes, specify treatment:	YES	NO
1.11	Current use of traditional or herbal remedies?	YES	NO

Medical Aid Number:_____ Dependent Code:_____ Patient Name:_____

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2. CLINICAL EXAMINATION

2.1	Weight		Kg		**2.2**	Height							cm		
2.3	If female:	Pregnant	Not Pregnant	If pregnant, expected date of delivery:			D	D	M	M	Y	Y	Y	Y	
2.4	Expected mode of delivery:	NVD	C / S	Expected date of C / S:			D	D	M	M	Y	Y	Y	Y	

2.5	**WHO Clinical Staging (please indicate disease below if Stage 3 or 4)**	**Tick Stage**	**1**	**2**	**3**	**4**

Clinical Stage 3 - Adult / Adolescent	**Please tick**	**Clinical Stage 4 - Adult / Adolescent / Paediatric**	**Please tick**
Unexplained severe weight loss (>10% of body weight)		HIV wasting syndrome (See Clinical Guidelines for definitions)	
Unexplained chronic diarrhoea > one month		Pneumocystis pneumonia	
Unexplained persistent fever > one month		Recurrent severe bacterial pneumonia	
Persistent oral candidiasis		Chronic herpes simplex infection	
Oral hairy leukoplakia		Oesophageal candidiasis	
Pulmonary tuberculosis		Extrapulmonary tuberculosis	
Severe bacterial infections (e.g pneumonia)		Kaposi's sarcoma	
Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis		Cytomegalovirus infection (retinitis or infection of other organs)	
Unexplained anaemia,neutropaenia,chronic thrombocytopaenia		Central nervous system toxoplasmosis	
Clinical Stage 3 – Paediatric		HIV encephalopathy	
Unexplained moderate malnutrition		Extrapulmonary cryptococcosis including meningitis	
Unexplained persistent diarrhoea (14 days or more)		Disseminated non-tuberculous mycobacterial infection	
Unexplained persistent fever > one month		Progressive multifocal leukoencephalopathy	
Persistent oral candidiasis (after first 6 weeks of life)		Chronic cryptosporidiosis	
Oral hairy leukoplakia		Chronic isosporiasis	
Acute necrotizing ulcerative gingivitis / periodontitis		Disseminated mycosis	
Lymph node TB		Recurrent septicaemia (including non-typhoidal Salmonella)	
Pulmonary TB		Lymphoma (cerebral or B-cell non-Hodgkin)	
Severe recurrent bacterial pneumonia		Invasive cervical carcinoma	
Symptomatic lymphoid interstitial pneumonitis		Atypical disseminated leishmaniasis	
Chronic HIV-associated lung disease including bronchiectasis		Symptomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomyopathy	
Unexplained anaemia,neutropenia,chronic thrombocytopenia			

2.6	Is there any degree of peripheral neuropathy?	YES	NO	If Yes, please specify:	Mild	Moderate	Severe
2.7	Is there any other significant clinical finding?	YES	NO	If Yes, please specify:			

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3. SPECIAL INVESTIGATION RESULTS (Please provide copies of reports. Please supply as many results as possible, including baseline results.)

Date Test Performed (DD/MM/YYYY)	CD4 count (cells / mm)	CD4 % (must be provided for children)	Viral Load (copies / ml)

Additional Investigations	Test Done?		If yes, results	Date Test Performed
Blood count(s) (Essential prior to approval of Zidovudine)	NO	YES		
Baseline ALT (Essential prior to approval of Nevirapine	NO	YES		
Serum creatinine/eGFR (Essential for patients with renal failure or prior to approval of Tenofovir)	NO	YES		

N.B.: 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 Aid for AIDS Clinical Guidelines will be considered for reimbursement. Please refer to these guidelines or contact Aid for AIDS on 0800 22 7700, or at afa@afadm.co.za for further information. Motivations will however always be considered. Please contact AfA for assistance if required.

4. MEDICATION (NB: Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated)

4.1 ANTIRETROVIRAL THERAPY	Strength (e.g. 10mg)	Directions (e.g. 1 tds)	Period in use (months)	Period required (months)

4.2 Other Medication Required (associated with the management of HIV)

DIAGNOSIS	MEDICINES	Strength (e.g. 10mg)	Directions (e.g. 1 tds)	Period in use (months)	Period required (months)

ACKNOWLEDGEMENT BY EXAMINING DOCTOR:

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 Aid for AIDS 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.

NB: 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.

Doctor's Signature	**Date**

Medical Aid Number:_____ Dependent Code:_____ Patient Name:_____

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