

Wellness screening (continued)

<p>HIV Test results</p> <p>What is your known HIV status?</p> <p>HIV Negative <input type="checkbox"/> HIV Positive <input type="checkbox"/> I don't know <input type="checkbox"/></p> <p>Screening test: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not done</p> <p>Confirmatory test <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not done</p> <p>First test ever? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>First test in 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>HIV self-reported risk assessment <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p>	<p>Maternity information</p> <p>Currently pregnant <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Estimated date of delivery <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td><td></td><td></td> </tr> </table></p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y	Y	Y	Y	M	M	D	D		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Y	Y	Y	Y	M	M	D	D														

TB Screening

Does your patient currently have TB?	<input type="checkbox"/> Y	<input type="checkbox"/> N	If yes: date TB treatment started:	<table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>M</td><td>M</td><td>D</td><td>D</td><td></td><td></td></tr></table>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Y	Y	Y	Y	M	M	D	D		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>															
Y	Y	Y	Y	M	M	D	D																	
If no: does your patient have the following:			Excessive night sweats?	<input type="checkbox"/> Y <input type="checkbox"/> N																				
Persistent cough for more than two weeks?	<input type="checkbox"/> Y <input type="checkbox"/> N		Presence of blood when coughing up phlegm?	<input type="checkbox"/> Y <input type="checkbox"/> N																				
Chest pain or difficulty breathing?	<input type="checkbox"/> Y <input type="checkbox"/> N		TB contact in the patient's household?	<input type="checkbox"/> Y <input type="checkbox"/> N																				
Fever for more than two weeks?	<input type="checkbox"/> Y <input type="checkbox"/> N		Sputum sample taken?	<input type="checkbox"/> Y <input type="checkbox"/> N																				
Unexplained significant weight loss?	<input type="checkbox"/> Y <input type="checkbox"/> N		Patient referred to State clinic	<input type="checkbox"/> Y <input type="checkbox"/> N																				

1. I acknowledge that by giving my consent on this form, I am giving my consent to the provisions outlined below which relate to the Bankmed Medical Scheme ("Bankmed"):
 - 1.1. Personal Health Assessment ("PHA") health screening tool and programme; and
 - 1.2. HIV counselling, testing and disease management programme ("HIV programme"), (collectively, the "Programmes").
2. I acknowledge that Bankmed, its administrators and/or managed healthcare organisation (collectively, the Bankmed Parties) will administer the Programme, including the information which I have provided in this document.
3. Although the Programmes are designed to:
 - 3.1. Identify certain health risks I may have and enrol me in the PHA programme; and/or
 - 3.2. Assess my medical risk and to enrol me on the HIV programme, any treatment or medicines prescribed (including antiretroviral treatment, if applicable), as well as the general management of my healthcare, is the sole responsibility of my healthcare provider(s), in consultation with me.
4. The Bankmed Parties are accordingly not liable for any claims by me or my dependants arising from any treatment or medicines prescribed, or arising from the implementation of the Programmes, save insofar as provided in the Bankmed rules.
5. I understand that no personal information provided by me in terms of the Programmes, including health status and treatment-related information, ("Personal Information"), will be disclosed to third parties (including my employer), other than Bankmed Parties and my healthcare provider(s), without my consent.
6. Consent for storing and accessing of my HIV results and HIV related information:

We are committed to protecting your right to privacy and your personal information, especially related to your HIV status. I hereby consent to the storing and accessing of my HIV results and HIV related information as follows:

To store my HIV results and HIV related information collected in the Clinical Data Repository (CDR). The CDR is a central store of clinical data housed outside of the various product house environments. It aims to provide one view of a member's latest medical history. Yes No
7. Whilst the Bankmed Parties will use their best endeavours to uphold the confidentiality of all my Personal Information, the Bankmed Parties will not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my Personal Information to a third party.
8. I can terminate my participation in the Programmes at any time with immediate effect on notice to a Bankmed Party, but understand that, in terms of the HIV programme, all benefits that I enjoyed under that programme shall immediately cease.
9. I acknowledge that should I not comply with the HIV programme protocols or prescribed treatment, Bankmed, in its sole discretion, may elect to exercise its rights and limit any benefits to the prescribed minimum benefits, always subject to the applicable legislation and the Bankmed rules.
10. I understand that telephone calls will be recorded for internal quality assurance purposes and, in respect of the HIV Programme, recorded calls will not be shared outside of the HIV programme unit.
11. The Bankmed parties will use the information to allocate the appropriate points to Balance, the Bankmed Wellness Programme.
12. I understand and acknowledge that "consent", for purposes of this document means my informed consent, in other words:
 - 12.1. I have read and understood the contents of this document.
 - 12.2. I understand and acknowledge the nature of the Personal Information that will be made available to and disclosed, used, processed and retained by the Bankmed Parties and my healthcare provider(s), as set out in this consent.
 - 12.3. I understand and acknowledge the purpose for which the Personal Information relating to me will be made available to, and disclosed, used, processed and retained by the Bankmed Parties and my healthcare provider(s), as set out in this consent.
 - 12.4. I have the legal capacity to give my informed consent, in other words, I am over the age of 18 years old and am able to fully understand and make decisions about my own healthcare

Counselling, not tested Counselling and agree to be tested Counselling, agree to be tested and participate in the HIVCare Programme

Signature

Date

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Y	Y	Y	Y	M	M	D	D		