

Significant past medical history, including opportunistic infections

Allergies				
Psychiatric				
Alcohol use				
Concomitant drug use				
Other				
Diabetes				
Hypercholesterolemia				
Depression/psychiatric care				
Cancer - chemotherapy				
Chronic renal failure				
Hypertension/cardiac failure (beta blockers or calcium channel blockers)				
Epilepsy				
Other meds i.e Warfarin, steroids				

OBSTETRIC HISTORY

Grav: Para:

Date of confinement Planned mode of delivery: Normal Vaginal delivery Caesarean section

Currently pregnant? Yes No Estimated delivery date

Desire to become pregnant? Yes No Contraception practised/practising

ALLERGIES

Drugs: Other:

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

WHO Clinical Stage 3 symptoms	<input type="checkbox"/>	WHO Clinical Stage 4 symptoms	<input type="checkbox"/>
Unexplained severe weight loss (>10% of body weight)	<input type="checkbox"/>	HIV wasting syndrome	<input type="checkbox"/>
Unexplained chronic diarrhoea > one month	<input type="checkbox"/>	Pneumocystis pneumonia	<input type="checkbox"/>
Unexplained persistent fever > one month	<input type="checkbox"/>	Recurrent severe bacterial pneumonia	<input type="checkbox"/>
Persistent oral candidiasis	<input type="checkbox"/>	Chronic herpes simplex infection (oralabial, genital or onorectal of more than one month's duration or visceral at any site)	<input type="checkbox"/>
Oral hairy leukoplakia	<input type="checkbox"/>	Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)	<input type="checkbox"/>
Pulmonary tuberculosis	<input type="checkbox"/>	Extrapulmonary tuberculosis	<input type="checkbox"/>
Severe bacterial infections (e.g. pneumonia)	<input type="checkbox"/>	Kaposi's sarcoma	<input type="checkbox"/>
Acute necrotising ulcerative stomatitis, gingivitis or periodontitis	<input type="checkbox"/>	Cytomegalovirus infection (retinitis or infection of other organs)	<input type="checkbox"/>
Unexplained anaemia, neutropaenia, chronic thrombocytopaenia	<input type="checkbox"/>	Ventral nervous system toxoplasmosis	<input type="checkbox"/>
Clinical Stage 3 – Paediatric	<input type="checkbox"/>	HIV encephalopathy	<input type="checkbox"/>
Unexplained moderate malnutrition	<input type="checkbox"/>	Extrapulmonary cryptococcosis including meningitis	<input type="checkbox"/>
Unexplained persistent diarrhoea (4 days or more)	<input type="checkbox"/>	Disseminated non-tuberculous mycobacteria infection	<input type="checkbox"/>

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

Persistent fever > one month	<input type="checkbox"/>	Progressive multifocal leucoencephalopathy	<input type="checkbox"/>
Persistent oral candidiasis (after first six weeks of life)	<input type="checkbox"/>	Chronic cryptosporidiosis	<input type="checkbox"/>
Acute necrotising ulcerative gingivitis or periodontitis	<input type="checkbox"/>	Chronic isosporiasis	<input type="checkbox"/>
Lymph node tuberculosis	<input type="checkbox"/>	Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)	<input type="checkbox"/>
Weakness, numbness or paraesthesias in hands or feet	<input type="checkbox"/>	Recurrent septicaemia (including non-typhoidal salmonella)	<input type="checkbox"/>

Has your patient been investigated or treated for TB?

Yes No

Date TB treatment started:

Treatment/Details:

Body mass:

kg

Height:

cm

CDC or WHO classification category:

Previous CD4 and viral load studies

CD4				Viral load			
Date	Result	Date	Result	Date	Result	Date	Result

Treatment

Date

Result

U&E – Pt on tenofovir

LFT – Pt on nevirapine

FBC – Pt on zidovudine

Previous antiretroviral therapy (ART) and HIV related prophylaxis

Medication	Dose	Date commenced	Date stopped	Reason stopped/side-effects

Current ART, prophylaxis and chronic medication

Medication	Dose	Date commenced	Date stopped	Reason stopped/side-effects

Has the patient been compliant with antiretroviral therapy?

Yes No

Detail/reason for non-compliance:

Diagnosis	Date when condition was first diagnosed	Medication name, strength and dosage	Number of repeats	How long has the patient used this medication?		May the patient use a generic medicine?		Reason if No
				Years	Months	Yes	No	
HIV								
Opportunistic infections								

We will approve funding for generic medication where available, unless you have indicated otherwise

Please note: Medikredit preferred pharmacy network is the Designated Service Provider for HIV medication. Include a prescription for the medication recommended for treatment.

Attachments: Copies of the following are to be attached to this application:

Confirmation of HIV status (ELISA) CD/Viral load results/FBC/ALT/CREATININE Prescription for medication recommended

Section 5: Healthcare Professional's details and consent

Surname Initials

Practice number Speciality

Physical address

Postal Code

Telephone No. Fax

Cellphone

E-mail

Preferred means of communication E-mail Fax

I confirm that the clinical details described in this document are to my knowledge accurate and correct. I understand that the Bankmed Medical Scheme HIV treatment protocols are guidelines only and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's HIV condition will reside with me. The reimbursement of therapy and related costs by the Scheme will be in accordance with the guidelines as well as the benefit available to the above patient from time to time.

Healthcare Professional's signature

Date