Application for GEMS HIV/AIDS Disease Management Programme

gems
Government Employees Medical Scheme

Date D D M M Y Y Y Y

Part 1: To be completed by the patient (or guardian)

Section A: Patient details

Surname First name

Gender M F ID no Date of birth D D M M Y Y Y Y

Membership no* Dependant code*

Option Tanzanite One Beryl Ruby Emerald Value Emerald Onyx

Telephone (H) ( ) Telephone (W) ( )

Cell phone* Email address

Preferred postal address for confidential mail

Postal Code

Preferred language of communication

Preferred way of communication (please tick one option) Tel (W) Tel (H) Cellphone Email Post

- I declare that I have received individual counselling and education on HIV/AIDS in a language that I understand and that I am able to make an informed decision on joining the GEMS HIV/AIDS Disease Management Programme (DMP).
- I understand the benefits and conditions of the GEMS HIV/AIDS DMP.
- I understand the purpose for doing pathology tests and that these tests are required as part of the GEMS HIV/AIDS DMP.
- I understand that I will be contacted regularly by a case manager or any other healthcare worker involved in my care.
- I understand that, even though I am on the GEMS HIV/AIDS DMP, my doctor retains a responsibility for my care, irrespective of the benefits authorised.
- I understand that all personal and clinical information supplied to the GEMS HIV/AIDS DMP will be used to access and manage my HIV/AIDS benefits.
- I hereby give my consent to the GEMS HIV/AIDS DMP to obtain my medical information from my healthcare providers (medical doctor, pharmacy, pathology and radiology).
- I authorise the GEMS HIV/AIDS DMP to disclose the clinical information relevant to my HIV condition without disclosure of my identity for the purpose of epidemiological/financial or scientific analysis and reporting.
- I confirm that the information provided in this application is true and correct and that I voluntarily subscribe to the GEMS HIV/AIDS DMP.
- I understand that the GEMS HIV/AIDS DMP shall use its best endeavours to uphold the confidentiality of all information related to my HIV condition.
- I understand that calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the HIV department.
- I acknowledge that my personal details above are treated as confidential and I accept that the GEMS HIV/AIDS DMP may use these contact details to communicate with me.

Patient/guardian signature _____ Date D D M M Y Y Y Y

The rest of the form to be completed by the attending practitioner

Please tick the correct option:

ART PMTCT PEP PrEP Paed (0-15 years) No ART

Section B: Designated practitioner details

Surname Initials Practice no

Telephone (H) ( ) Telephone (W) ( )

HPCSA no* Cell phone no Fax no ( )

Email

Section C: Clinical information

Date of HIV diagnosis D D M M Y Y Y Y

In the past 24 months was the patient diagnosed with TB? ☐ Yes ☐ No

If yes, date TB treatment started D D M M Y Y Y Y TB treatment end date D D M M Y Y Y Y

☐ Drug resistant TB ☐ Drug sensitive TB ☐ Unknown

Has the patient been diagnosed with TB Meningitis?	☐ Yes	☐ No
Does the patient have an active psychiatric disease?	☐ Yes	☐ No
If yes, with depression?	☐ Yes	☐ No
Cryptococcal Meningitis?	☐ Yes	☐ No
Has the patient diagnosed or tested for chronic renal disease?	☐ Yes	☐ No
Previous ART (excluding PMTCT)?	☐ Yes	☐ No
Previous ART for PMTCT?	☐ Yes	☐ No
Currently on ART?	☐ Yes	☐ No
Is this a test and treat enrolment (CD4>500)?	☐ Yes	☐ No

If patient is between 15-19 years a urine dipstick is required ☐ Normal ☐ Abnormal ☐ Proteinurea ☐ Yes ☐ No

Allergies: _____

WHO Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

WHO CLINICAL STAGE 3 SYMPTOMS		WHO CLINICAL STAGE 4 SYMPTOMS	
Unexplained severe weight loss (>10% of body weight)		HIV wasting syndrome	
Unexplained chronic diarrhoea > one month		Pneumocystis pneumonia	
Unexplained persistent fever > one month		Recurrent severe bacterial pneumonia	
Persistent oral candidiasis		Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)	
Oral hairy leukoplakia		Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)	
Pulmonary tuberculosis		Extrapulmonary tuberculosis	
Severe bacterial infections (e.g. pneumonia)		Kaposi's sar	
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 mycobacteria infection	
Persistent fever > one month		Progressive multifocal leucoencephalopathy	
Persistent oral candidiasis (after first six weeks of life)		Chronic cryptosporidiosis	
Acute necrotizing ulcerative gingivitis or periodontitis		Chronic isosporiasis	
Lymph node tuberculosis		Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)	
Weakness, numbness or paraesthasias in hands or feet		Recurrent septicaemia (including non-typhoidal salmonella)	

PMTCT

Estimated date of delivery D D M M Y Y Y Y

PEP

Date of incident D D M M Y Y Y Y

Type of exposure ☐ Sexual exposure ☐ Blood exposure

Indicate if the patient tested using an HIV ELISA test	☐ Yes	☐ No
Indicate if the patient was tested using an HIV Rapid test	☐ Yes	☐ No

PrEP

Reason* ☐ Discordant couple ☐ MSM

Confirmation of HIV-positive partner reviewed by practitioner ☐ Yes ☐ No

Is HIV-positive partner on GEMS? ☐ Yes ☐ No Membership no. ☐☐☐☐☐☐☐☐☐

Section D: Measurements and pathology

Weight ☐☐☐ kg

Height ☐☐☐ cm

LATEST HIV PATHOLOGY RESULTS (COMPLETE OR ATTACH RESULTS)

TEST	DATE	RESULT
CD4 cell count*	Y Y Y Y M M D D	/mm3
CD4 % (child <12 years)	Y Y Y Y M M D D	%
VL*	Y Y Y Y M M D D	copies/ml

OTHER RESULTS

TEST	DATE	RESULT	
RPR	Y Y Y Y M M D D	Pos:	Neg:
Hep B sAg	Y Y Y Y M M D D	Pos:	Neg:
Hb	Y Y Y Y M M D D	g/dl	
Creatinine*	Y Y Y Y M M D D	mMol/l	
eGFR*	Y Y Y Y M M D D		
TB sputum	Y Y Y Y M M D D	Pos:	Neg:
PAP smear	Y Y Y Y M M D D		
ALT	Y Y Y Y M M D D		
U&E – Pt on tenofovir	Y Y Y Y M M D D		
LFT – Pt on nevirapine	Y Y Y Y M M D D		
FBC – Pt on zidovudine	Y Y Y Y M M D D		

Section E: ART information

PREVIOUS ANTI-RETROVIRAL THERAPY (ART) AND HIV-RELATED PROPHYLAXIS

MEDICINE	DOSE	DATE COMMENCED	DATE STOPPED	REASON STOPPED/SIDE-EFFECTS
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	

CURRENT ART, PROPHYLAXIS AND CHRONIC MEDICINE

MEDICINE	DOSE	DATE COMMENCED	DATE STOPPED	REASON STOPPED/SIDE-EFFECTS
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	
		Y Y Y Y M M D D	Y Y Y Y M M D D	

Keep current ARTs? ☐ Yes ☐ No If no, indicate new ARTs on the following page.

NEW ART, PROPHYLAXIS AND CHRONIC MEDICINE

MEDICINE	DOSE	DATE COMMENCED								DATE STOPPED								REASON STOPPED/SIDE-EFFECTS
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

PMTCT: ART FOR BABY, PROPHYLAXIS AND CHRONIC MEDICINE

MEDICINE	DOSE	DATE COMMENCED								DATE STOPPED								REASON STOPPED/SIDE-EFFECTS
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

PLEASE NOTE: Include a prescription for the medicine recommended for treatment.

ATTACHMENTS: Copies of the following have been attached to this application

☐ Confirmation of HIV status (ELISA) ☐ CD/Viral load result/Hb/ALT/CREATININE ☐ Prescription for medicine recommended

- I certify that the above particulars are to the best of my knowledge accurate.
- I confirm that I have disclosed the results to the member and have given the required counselling including the importance of adhering to the treatment plan, which includes regular follow-ups and medicine compliance.
- I hereby authorise GEMS to process and submit a claim for payment under tariff code 0199 on my behalf, as reimbursement for completing this registration form. I confirm that I will not submit a separate claim. NB: Tariff code 0199 will only be paid for first time completion of the registration form.

Doctor's signature _____ Date D D M M Y Y Y Y

*These fields are required to complete the enrolment on the HIV/AIDS DMP.