



QUALSA

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APPLICATION FORM

HIV RISK MANAGEMENT

SECTION 1: MAIN MEMBER DETAILS

MEMBER SURNAME	<input type="text"/>	TITLE	<input type="text"/>	INITIALS	<input type="text"/>	
MEMBER NUMBER	<input type="text"/>	MEDICAL SCHEME	<input type="text"/>			
PHYSICAL ADDRESS	<input type="text"/>					
	<input type="text"/>				POSTAL CODE	<input type="text"/>

SECTION 2: PATIENT DETAILS

DEPENDANT CODE	<input type="text"/>	SURNAME	<input type="text"/>				
FIRST NAME	<input type="text"/>					TITLE	<input type="text"/>
DATE OF BIRTH	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
TELEPHONE NO.	<input type="text"/>	<input type="text"/>	(H)	<input type="text"/>	<input type="text"/>	(W)	
FAX NO.	<input type="text"/>	<input type="text"/>	CELL	<input type="text"/>	<input type="text"/>		
E-MAIL ADDRESS	<input type="text"/>						
PREFERRED POSTAL ADDRESS	<input type="text"/>					POSTAL CODE	<input type="text"/>

SECTION 3: PATIENT CONSENT (TO BE SIGNED BY THE MEMBER/OR GUARDIAN IF PATIENT IS A MINOR)

- I hereby confirm that the information provided in this application is true and correct.
- I acknowledge that Qualsa is the administrator of the Programme and that any anti-retroviral treatment prescribed as well as the general management of my HIV condition shall be the sole responsibility of my medical practitioners. Qualsa and my medical aid scheme ("the scheme") shall accordingly not be liable for any claims by me or my dependants arising from the implementation of the Programme.
- I hereby give my consent to my medical practitioner to provide the Programme's Case Managers with clinical information pertinent to the management of my HIV infection.
I furthermore agree to the Programme's Case Managers sharing this information with any other healthcare worker involved in my care (including hospital risk management professionals appointed by the scheme).
- I understand that no information regarding my case will be made available to my employer(s) or any other person not directly involved in my care.
- Whilst Qualsa shall use its best endeavours to uphold the confidentiality of all information disclosed to it, Qualsa shall not be liable for any claims by me or my dependants arising from any unauthorised disclosure of my personal information to a third party.
- I shall be entitled to terminate my participation in the Programme at any time with immediate effect, but understand that:
 - all the benefits that I enjoy under the Programme shall immediately cease and the scheme shall not be obliged to reinstate such benefits at any time thereafter; and
 - that the consequences of such a decision will rest with me alone.
- I acknowledge that should I not comply with the programme protocols or prescribed treatment, that the scheme at its sole discretion, may elect to exercise its rights and limit my benefits to the prescribed minimum benefits as legislated.

SIGNED
(Patient/Guardian (member))

DATE

ASSISTED BY ATTENDING DOCTOR

SURNAME	<input type="text"/>	INITIALS	<input type="text"/>
PRACTICE NUMBER	<input type="text"/>		

SIGNED

DATE

SECTION 4: GENERAL PATIENT INFORMATION TO BE COMPLETED BY THE ATTENDING DOCTOR

Male Female

Date of HIV diagnosis

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

 Test used: _____

Reason for testing: _____

Has counselling been given?

YES	NO
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 If so, by whom: _____

SIGNIFICANT PAST MEDICAL HISTORY, INCLUDING OPPORTUNISTIC INFECTIONS

	DATE	DURATION	TREATMENT RECEIVED	OUTCOME
Operations/hospital admissions (especially if related to HIV infection)				
Illnesses				

OBSTETRIC HISTORY

Grav: _____

Para: _____

Date of last confinement:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Currently pregnant?

YES	NO
-----	----

 EDD

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Desire to become pregnant?

YES	NO
-----	----

Contraception practised: _____

EXPOSURE OF SPOUSE/PARTNER/INFANT TO PATIENT (POSSIBLE TRANSMISSION):

CONTACT	KNOWN HIV STATUS

ALLERGIES Drugs: _____

Other: _____

ALCOHOL USE

_____ per day

_____ per week

Have you consistently taken more in the past?

YES	NO
-----	----

SYMPTOMS EXPERIENCED BY PATIENT OVER PAST 6 MONTHS

SYMPTOM/SIGN	FREQUENCY IN LAST 6 MONTHS	DESCRIBE
GENERAL		
Unexplained fevers		
Loss of weight		
Night sweats		
SKIN		
Rashes		
Shingles		
EAR, NOSE & THROAT		
Oral thrush		
Dysphagia		
RESPIRATORY		
Shortness of breath/coughing		
Chest infections		
Sinusitis		
UROGENITAL SYSTEM		
Genital thrush/infections		
NERVOUS SYSTEM		
Persistent headache		
Confusion or dizziness		
Weakness, numbness or paraesthesia in hands or feet		
GASTROINTESTINAL SYSTEM		
Nausea and vomiting		
Persistent diarrhoea		

Has your patient been investigated or treated for TB?

YES	NO
-----	----

Details _____

ABNORMAL CLINICAL SIGNS PRESENT AT TIME OF APPLICATION (please describe)

1. General appearance _____
 2. ENT _____
 3. Skin _____
 4. Lungs _____
 5. Abdomen _____
 6. CNS/PNS _____
- Body Mass _____ kg Height _____ cm CDC or WHO classification category _____

SECTION 5: PREVIOUS CD4 & VIRAL LOAD STUDIES

CD4				VIRAL LOAD			
DATE		RESULT		DATE		RESULT	

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

MEDICATION	DOSE	DATE COMMENCED	DATE STOPPED	REASON STOPPED/SIDE-EFFECTS
CURRENT ART, PROPHYLAXIS AND CHRONIC MEDICATION				

Has the patient been compliant with anti-retroviral therapy? YES NO

Detail/reason for non-compliance: _____

How many days has the patient been absent from work in the last 12 months as a direct result of HIV infection? _____

How frequently has the patient visited you in the last 12 months for the purpose of monitoring the HIV disease? _____

In your opinion, is the patient likely to comply with long-term ART? YES NO MAYBE

TREATMENT BEING REQUESTED (As per available benefits and treatment protocols)

MEDICATION	DOSE

SECTION 6: DOCTOR'S DETAILS

INITIALS SURNAME

PRACTICE NUMBER SPECIALITY

PHYSICAL

ADDRESS

TELEPHONE NO. (W) FAX

CELL E-MAIL

POSTAL CODE

Do you wish to dispense anti-retroviral therapy (ART)? YES NO

SECTION 7: DOCTOR'S CONSENT

I confirm that the clinical details described in this document are to my knowledge accurate and correct. I understand that the Qualsa HIV treatment protocols are guidelines only and that the ultimate responsibility regarding anti-retroviral 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.

DOCTOR'S SIGNATURE

DATE

SECTION 8: ATTACHMENTS

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

Confirmation of HIV status (ELISA) CD4/Viral load results

Send Application Form to: Fax: 0861 888 301; Mail: PO Box 15468, Vlaeberg 8018
For assistance: Tel: 0861 888 300; E-mail: hiv@qualsa.co.za