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DISEASE MANAGEMENT FORM
PAEDIATRICS INTAKE FORM

Forward to: MyHealth Administrators, Maerua Office Park, Robert Mugabe Avenue, Windhoek
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Administrators of **Vitality** **Aids Outreach Programme** **Metropolitan Workplace Solution**
 Private Medical Aid Funds Namibia Medical Care
 RCC Bankmed Namibia
 Renaissance Medical Aid
 Employer Groups



1. Patient Surname..... First Name..... Date of birth.....

2. Consultation date..... Medical Aid..... Medical Aid No.....

3. Male Female

4. Significant past Medical history, including opportunistic infections etc over the past 6 months

Date	Condition/Illness	Treatment Received	Outcome

5. Presenting Symptoms (please tick)

General <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Night sweats <input type="checkbox"/> Pedal swelling <input type="checkbox"/> Yellow eyes <input type="checkbox"/> Weight loss	Nervous <input type="checkbox"/> Headache <input type="checkbox"/> Dizziness <input type="checkbox"/> Convulsions	Urogenital <input type="checkbox"/> Painful urination	Gastrointestinal <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Painful swallowing <input type="checkbox"/> Anal bleeding
Skin/Musculoskeletal Rashes <input type="checkbox"/> Lumps	ENT/Mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth sores <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Blocked nose	Respiratory <input type="checkbox"/> Dry cough <input type="checkbox"/> Productive cough <input type="checkbox"/> Chest pain <input type="checkbox"/> Difficulty breathing	Cardiovascular <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations

6. General examination Wt.kg Ht.cm T.....°C BP.....mmHG P.....min
 Lymphadenopathy Jaundice Pallor

7. Baseline physical examination (very important to enable MyHealth to track sites of OI's and toxicities)

Nervous.....
 ENT/Mouth.....
 Resp/Chest.....
 Cardiovascular.....
 Abdomen.....
 Urogenital.....
 Anorectal.....
 Skin/Musculoskeletal.....

8. Laboratory results

Date	Test	Result	Date	Test	Result
	HIV 1 and 2			Glucose	
	CD4 CD4 %			HBsAg	
	Viral load/log			HB	
	ALT			Creatinine	

9. Previous ARVs exposure: None HAART PMTCT PEP

10. Specify regimen if any of (9) above is applicable.....

11. If previous HAART, started when?..... Stopped when?.....

12. Reason for stopping HAART previously.....

13. Revised WHO staging for paediatrics (please place a tick)

Clinical stage 1

- Asymptomatic
- PGL

Clinical stage 2

- Hepatosplenomegaly
- Papular pruritic eruptions
- Seborrhoeic dermatitis
- Extensive human papilloma virus infection
- Extensive molluscum contagiosum
- Fungal nail infections
- Recurrent oral ulcerations
- Lineal gingival erythema (LGE)
- Angular cheilitis
- Parotid enlargement
- Herpes zoster
- Recurrent or chronic RTI's (otitis media, otorrhoea, sinusitis)

Clinical stage 3

- Moderate unexplained malnutrition (not adequately responding to standard therapy)
- Unexplained persistent diarrhoea (14 days or more)
- Unexplained persistent fever (intermittent or constant for longer than one month)
- Oral candidiasis (outside neonatal period)
- Oral hairy leukoplakia
- Acute necrotizing ulcerative gingivitis or periodontitis
- Pulmonary TB
- Severe recurrent presumed bacterial pneumonia

Clinical stage 4

- Severe unexplained wasting or malnutrition (not adequately responding to standard therapy)
- Pneumocystis pneumonia
- Recurrent severe presumed bacterial infections (e.g. empyema, pyomyositis, bone or joint infection, meningitis, but excluding pneumonia)
- Chronic herpes simplex infection (orolabial or cutaneous of more than one month's duration)
- Oesophageal candidiasis
- CNS toxoplasmosis (outside the neonatal period)
- HIV encephalopathy
- Progressive multifocal leukoencephalopathy (PML)
- HIV-associated cardiomyopathy or HIV-associated Nephropathy

14. WHO stage 1 2 3 4

15. ARV regimen, prophylaxis and vitamins prescribed today

Medication	Dose / Frequency	Date Started

16. Presently on TB treatment? Yes No If yes, regimen.....Started.....

17. Doctor's Consent

I confirm that the clinical details provided in this document are correct and factual. I understand and accept that MyHealth Administrators' treatment protocols are guidelines only and ultimate responsibility for the patient regarding anti-retroviral therapy and general management of the patients' HIV condition is my professional prerogative. Further, I understand that the reimbursement of therapy and related costs by the scheme will be in accordance with the guidelines as well as the benefits available to the above patient from time to time.

Doctor's full names..... Doctor's signature.....Date.....

Please fax both pages this form, the patient consent form and copies of lab results to 061-375969.