NMC Building, 8 Newton Street
PO Box 97156, Maerua Mall, Windhoek, Namibia
Tel: 061 375 950 | Fax 061 375 969
Email: mhsp@methealth.com.na
Website: www.mhnamibia.com

MyHealth Administrators

HIV RISK MANAGEMENT APPLICATION FORM

Antiretroviral (ARV) On-Going Treatment

A. Important Information: *(This form must be completed by members of NMC and PSEMAS.)*

- This application form is to enrol in the HIV Clinical Management Programme.
- Complete PrEP or PEP treatment forms separately.
- HIV clinical management benefits and the authorisation of the medications thereof are subject to the rules, terms and conditions of medical aid funds (NMC and PSEMAS).
- Once the medications are authorised, MyHealth will send the authorisation letter(s) instantly to the medical practitioner.
- MyHealth will send treatment and blood monitoring review letters directly to the member (optional). Please indicate how you prefer to receive confidential information if you consent.
- Members should sign the form as consent – the parent/guardian should sign in the case of a minor.
- Counselling is critical; thus, our counsellors will contact the member once the registration process is completed and continuously provide adherence and psycho-social support.
- Submit all relevant and correct information documents on time to avoid delays. Please complete all sections.*
- Signing the forms indicates that you agree with the terms and conditions of the HIV Clinical Management Programme.
- Email completed forms, blood results, and all relevant documentation to mhsp@methealth.com.na.

**This form is subjected to renewal after 12 months.*

B. Patient's Personal and Clinical Details*

Surname

First Names

Gender M F Date of Birth: D D M M Y Y Marital Status: Single Married Divorced Child

Cell Phone Number Email Address *(confidential)*

Postal Address City/Town Region:

Preferred Language

C. Medical Aid Details*

Medical Aid Fund: (choose the correct fund) NMC PSEMAS Option:

Medical Aid Number: Membership/Dependant's Code:

D. Confidential Contacts*

Preferred mode to receive confidential information (choose one option) Email SMS Postal Letter

Can we send you an SMS reminder when the medications and blood tests are due? Yes No

If yes, preferred cell phone number

I hereby declare that the information provided in this form is true and correct; my doctor has provided me with all the information required to start my treatment. In the same vein, I have consented to my medical practitioner, hospital or laboratory to provide Myhealth Administrators with the required and relevant clinical information needed to improve my health and that of my dependants. Whilst Myhealth Administrator shall uphold the confidentiality of all the information disclosed to them, I understand that I will be liable for any medical expenses not covered by the HIV benefits.

Patient Signature/Guardian or Parent (if a minor) Date D D M M Y Y

*Parent/Guardian's Name (signing the form) **Cell Phone Number**

NMC NAMIBIA MEDICAL CARE PSEMAS

E. Clinical Information and Examination *(Completed by the Dr.)**

Antiretroviral treatment (ART): (please tick the correct option)

1. ART (adults) ☐ ART (pediatrics & adolescents, 0 -18 years) ☐ HIV diagnosis date D D M M Y Y
   (Please load/attach blood tests results)
2. ICD10 ______ Primary ICD10 ______ Secondary ICD10 ______
3. Transferred from other ART programmes? Yes No State ☐ Other medical aid fund ☐ Name ______
   Previous Medical Aid Number ______
4. Partner's HIV status is known? Yes No If yes, are they on ART? Yes No If yes, provide current VL results Yes No Unknown
5. Was the mother on PMTCT programme? Yes No
6. Baseline pathology tests done (CD4 count, viral load, FBC, LFT, Hepatitis B surface Antigen, glucose, U & E, lipogram) Yes No
   (Please upload/attach blood tests results)
7. Counselling provided at the Dr's practice? Yes No
8. HIV status disclosed to any other person besides the member? Yes No If yes, to whom? (specify) ______
9. Does the member have a treatment supporter? Yes No If yes, name of supporter ______
   Cell Phone Number ______ Do you give consent to Myhealth to contact the treatment supporter? Yes No
10. Is the member pregnant? Yes No N/A If yes, EDD D D M M Y Y
11. Contraceptives Yes No If yes, Specify ______ Hormonal Therapy Yes No
12. Weight ______ kg Height ______ cm *Very critical for pediatric dosage calculation
13. Was cervical cancer screening done? Yes No If yes, specify ______
    Results ______
14. Circumcised Yes No
15. Vaccinated HPV Yes No
16. Was TB screening done? Yes No If yes, assessment: Current Cough Yes No Fever Yes No
    Weight Loss Yes No Night Sweat Yes No Lymph Node Enlarged Yes No
17. TB positive Yes No If Yes, how long current on TB treatment ______ Attach TB regimen
18. Other chronic conditions the member diagnosed with or treated for:
    Diabetes ☐ Hypertension ☐ Hyperlipidemia ☐ Epilepsy ☐ Mental illness ☐
    CKD ☐ COPD/ Asthma ☐ Chronic Hepatitis B ☐ TB ☐
    Cancer (specify) ______ Others (Specify) ______
19. Opportunistic Infections Yes No if Yes, Specify ______
20. Exposed to HIV medications before? Yes No Was ART stopped? Yes No When? D D M M Y Y
21. PMTCT Yes No PEP Yes No PrEP Yes No
22. Reasons for RX discontinuation: Side effects ☐ Resistance ☐ Cost ☐ Default ☐ Others ☐
    (specify)

23. Revised WHO clinical staging for adults and adolescents' presumptive clinical diagnosis only

Clinical Stage 1

- [ ] Asymptomatic
- [ ] Persistent generalised lymphadenopathy (PGL)

Clinical Stage 2

- [ ] Moderate unexplained weight loss of presumed or measured body
- [ ] Herpes zoster
- [ ] Recurrent respiratory tract infections (RTIs, sinusitus, bronchitis, otitis media,
- [ ] Angular cheilitis
- [ ] Recurrent oral ulcerations
- [ ] Papular pruritic eruptions
- [ ] Seborrhoeic dermatitis
- [ ] Fungal nail infections of fingers

Clinical Stage 3

- [ ] Severe weight loss (>IO% of presumed or measured body weight)
- [ ] Oral candidiasis
- [ ] Unexplained chronic diarrhoea for longer than one month
- [ ] Oral hairy leukoplakia
- [ ] Unexplained persistent fever (intermittent or constant for longer than one month)
- [ ] Pulmonary tuberculosis (TB) diagnosed in the last two years
- [ ] Acute necrotising ulcerative stomatitis, gingivitis or periodontitis
- [ ] Severe presumed bacterial infections (e.g., pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, and bacteremia.)

Clinical Stage 4

- [ ] HIV wasting syndrome
- [ ] Pneumocystis pneumonia
- [ ] Recurrent severe or radiological bacterial pneumonia
- [ ] Chronic herpes simplex infection (Orolabial, genital or anorectal of more than one month's duration)
- [ ] Oesophageal candidiasis
- [ ] Extrapulmonary TB
- [ ] Kaposi's sarcoma
- [ ] Central nervous system (CNS) toxoplasmosis

- [ ] HIV encephalopathy
- [ ] Extrapulmonary cryptococcosis including meningitis
- [ ] Stage 1
- [ ] Stage 2
- [ ] Stage 3
- [ ] Stage 4

*Previous HIV Medicines & Strengths	Initiated Date						Date Stopped					
	D	D	M	M	Y	Y	D	D	M	M	Y	Y
	D	D	M	M	Y	Y	D	D	M	M	Y	Y
	D	D	M	M	Y	Y	D	D	M	M	Y	Y

F. Current HIV Medications*

ICD-10 CODE	Medications Prescribed: Name, Strengths and Dosage	Initiated Date						Any Remarks
		D	D	M	M	Y	Y	
		D	D	M	M	Y	Y	
		D	D	M	M	Y	Y	
		D	D	M	M	Y	Y	

G. Medical Practitioners Details*

Doctor's Surname ______________________ Initials ______________________

Practice Number ______________________ Contact Number ______________________

Email Address ______________________ Fax Number ______________________

I hereby declare that the information provided in this application form is correct and the patient comprehends all the information regarding the treatment.

Doctor's Signature ______________________ Date | D | D | M | M | Y | Y |

The outcome of this application will be communicated to you by email.