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HIV RISK MANAGEMENT APPLICATION FORM

ARVs On-going Treatment

A. Important Information: *(This Form Must be Completed by Members of NMC, BANKMED and PSEMAS.)*

- This application form is to enrol on 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 the relevant Medical Aid Funds (NMC/Bankmed/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 would 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 wellness1@methealth.com.na.

**The forms are subject 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

C. Medical Aid Details*

Medical Aid Fund: *((Please tick the Correct Fund)* NMC ☐ Bankmed ☐ PSEMAS ☐ Option:

Medical Aid Number: Membership Code:

D. Preferred Communication Method*

Preferred mode to receive confidential information *(Pleas tick one option)* Email ☐ Postal Letter ☐

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

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 at all times. 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 Cell Phone Number

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

Please tick the correct option

1. **ART Adults** ☐ ART (Pediatric - Adolescents 0-18 years) ☐ HIV Diagnosis Date *(Please Load/Attach Blood Tests Results)* D D M M Y Y

2. **Baseline Pathology Tests Done (CD4, VL, FBC, LFT, HBV, Glucose, U&E, Lipogram)**: *(Please Load/Attach Blood Tests Results)* Yes No

3. **Counselling Provided at the Dr's Practice?** Yes No

4. **HIV Status Disclosed** Yes No If Yes, to Whom? (Specify) _____

5. **Is the Member Pregnant?** Yes No N/A If yes, EDD D D M M Y Y

6. **Weight** _____ kg Height _____ cm

7. **Clinical Staging (WHO Stages)** Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4 ☐

7.1 Specific Observations/ Information on the Clinical Stage: _____

_____

_____

8. **Other Chronic Conditions the Member Diagnosed with or Treated for:**

Diabetic ☐ Hypertension ☐ High Cholesterol ☐ Epilepsy ☐ Depression or Any Mental Disorders ☐

Bone Marrow Disorders ☐ Deep vein Thrombosis ☐ Parkinson Disease ☐ Hepatitis ☐ TB ☐

Cancer (specify): _____

9. **Exposed to HIV Medications Before?** Yes No Was ART Stopped? Yes No When

10. **Reasons for RX Discontinuation**: Side Effects ☐ Resistance ☐ Cost ☐ Default ☐ Others ☐

(specify): _____

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

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. I understand and accept that MyHealth Administrators' treatment protocols, as guided by the National ART Guidelines of the Ministry of Health and Social Services, are only guidelines. The ultimate responsibility for the patient regarding the anti-retroviral therapy and general management of the patient's HIV condition is my professional prerogative. Furthermore, I understand that the reimbursement of therapy and related costs by the medical aid scheme will be in accordance with the ART guidelines and the benefits available to the above patient from time to time. Thus, MyHealth will not be held accountable for any unpaid claims if benefits are depleted.

Doctor's Signature: _____ Date D D M M Y Y

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