A MEMBER APPLICATION FORM

DISEASE MANAGEMENT FORM

ALL MEMBERS TO COMPLETE UPON FIRST CONSULTATION

Forward to: MyHealth Administrators, Maerua Office Park, Robert Mugabe Avenue, Windhoek
P.O.Box 97156, Maerua, Windhoek, Namibia • Tel: +264 61 375 950 • Fax: +264 61 375 969
E-mail: info@mhnamibia.com.na • Website: www.mhnamibia.com

Administrators of **Aids Outreach Programme**
Namibia Medical Care
Bankmed Namibia

1. **Member Details**

Member Surname .... **First Name** .... **Date of birth** ....

Identity Number .... **Medical Aid** ....

Medical Aid No. .... **Telephone No. (w)(......)** .... **(h)(......)** ....

Cellphone No. .... **Postal address** ....

2. **Member Consent**

I wish to enrol myself/my dependant on the Disease Management Progamme offered by MyHealth Administrators.

I authorise MyHealth Administrators to pay claims for medical treatment on my behalf. MyHealth Administrators shall use such funds for the treatment of the HIV condition of myself, or my dependant or both.

I understand that I will be liable for any claims relating to the medical costs related to the treatment of my HIV condition if there are no funds available to me on my withdrawal from the Disease Management Progamme, or in the case of my death. This applies to my dependant too.

I hereby confirm that the information provided in this enrolment form is true and correct. I acknowledge that MyHealth Administrators is the administrator of the Case Management Progamme and that any anti-retroviral treatment prescribed as well as the general management of any HIV condition shall be the sole responsibility of my medical practitioner. MyHealth Administrators and my employer shall accordingly not be liable for any claims by me or my dependants or any third parties, arising from the implementation of the Disease Management Programme.

I irrevocably give my consent to any medical practitioner, hospital, laboratory or any other person who may be in possession of any information concerning my health or my dependant's health, to provide MyHealth Administrators with such clinical information pertinent to my HIV management at MyHealth Administrators' request.

Whilst MyHealth Administrators shall use their best endeavours to uphold the confidentiality of all information disclosed to it, MyHealth Administrators shall not be liable for any claims by me or my dependants or third parties arising from any unauthorised disclosure of information pertinent to the management of my HIV infection to a third party. Nevertheless, owing to the complexity of HIV management, I authorise MyHealth Administrators to, when necessary, consult best international expertise in order to support my physician's management of my HIV, but on a strict proviso that neither my name nor any other form of my identification shall be made known to such international experts. This applies to my dependant too.

....
Patient's Signature **Date**

3. **Doctor Details**

Doctor Surname .... **Doctor Initials** ....

Practice Name .... **Practice Number** ....

Telephone No. (......) .... **Fax No. (......)** .... **Cellphone No.** ....

Postal address ....

E-mail address ....

Please fax this form to 061-375969.

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B

INTAKE FORM

DISEASE MANAGEMENT FORM

ADULT INTAKE FORM

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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	On Treatment

5. **Presenting Symptoms** (please tick ☑)

General
- ☐ Fever
- ☐ Malaise
- ☐ Night sweats
- ☐ Pedal swelling
- ☐ Yellow eyes
- ☐ Weight loss

ETN/Mouth
- ☐ Sore throat
- ☐ Mouth sores
- ☐ Nasal discharge
- ☐ Blocked nose

Nervous
- ☐ Headache
- ☐ Dizziness
- ☐ Sleeplessness
- ☐ Convulsions
- ☐ Numbness
- ☐ Confusion

Skin/Musculoskeletal
- ☐ Rashes
- ☐ Lumps
- ☐ Loss of fat

Urogenital
- ☐ PV bleeding
- ☐ PV discharge
- ☐ Genital ulcers
- ☐ Genital growths
- ☐ Painful urination
- ☐ Urethral discharge

Respiratory
- ☐ Dry cough
- ☐ Productive cough
- ☐ Chest pain
- ☐ Difficulty breathing

Gastrointestinal
- ☐ Vomiting
- ☐ Nausea
- ☐ Diarrhoea
- ☐ Constipation
- ☐ Painfull swallowing
- ☐ Anal bleeding

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

6. **General examination Wt.** .... kg **Ht.** .... cm **Temp** .... °C **BP** .... mmHG

☐ Peripheral lymphadenopathy ☐ Jaundice ☐ Pallor ☐ Cyanosis ☐ Peripheral oedema

7. **Baseline Laboratory results** (please attach copies of all baseline tests)

Date	Test	Result	Date	Test	Result
	HIV 1 and 2			Lymphocytes	
	CD4 + count			Platelets	
	CD4 + %			ALT	
	Viral load copies/ml			Creatinine	
	Viral load log			Glucose	
	HB			HBsAg	

8. **Pregnant?**
- ☐ N/A
- ☐ Yes
- ☐ No
- ☐ LMP........
- ☐ Papsmear

9. **Contraceptives use**
- ☐ Oral
- ☐ Injection
- ☐ Regular Condom Use
- ☐ Other
- ☐ None

10. **Previous ARVs exposure**
- ☐ None
- ☐ HAART
- ☐ PMTCT
- ☐ PEP (occupational exposure/rape?)

11. **Status of Partners**
- ☐ On treatment
- ☐ Tested
- ☐ Unknown
- ☐ Informed

12. **If previous HAART, started on** .... **and stopped on** ....

B(back side)

13. **Revised WHO staging for adults and adolescents - presumptive clinical diagnosis only** (please place a tick ☑)

Clinical stage 1

- ☐ Asymptomatic
- ☐ Persistent generalised lymphadenopathy (PGL)

Clinical stage 2

- ☐ Moderate unexplained weight loss (<10% of presumed or measured body weight)
- ☐ Recurrent respiratory tract infections (RTIs, sinusitus, bronchitis, otitis media, pharyngitis)
- ☐ Herpes zoster
- ☐ Angular cheilitis
- ☐ Recurrent oral ulcerations
- ☐ Papular pruritic eruptions
- ☐ Seborrhoeic dermatitis
- ☐ Fungal nail infections of fingers

Clinical stage 3

- ☐ Severe weight loss (>10% of presumed or measured body weight)
- ☐ Unexplained chronic diarrhoea for longer than one month
- ☐ Unexplained persistent fever (intermittent or constant for longer than one month)
- ☐ Oral candidiasis
- ☐ Oral hairy leukoplakia
- ☐ Pulmonary tuberculosis (TB) diagosed in last two years
- ☐ Severe presumed bacterial infections (e.g. Pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, Bacteremia)
- ☐ Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis

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

14. **ARV regimen, prophylaxis and vitamins prescribed today**

Medication	Dose / Frequency	Date Started

15. **Other medication(s) prescribed for acute/chronic co-morbidities**

Condition	Medication

16. **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 patient's 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 patient from time to time.

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

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

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