

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 form is used to enrol a member who has tested HIV positive into the HIV Clinical Management Programme.
- The form must be completed in full at the point of care by the healthcare provider (doctor, nurse).
- All required fields must be completed for registration eligibility.
- A valid email address must be provided for confidential communication; without this, communication with the Programme might be challenging.
- For minors, the parent/guardian's name and contact details must be recorded.
- If required documents or information are missing, the form will remain in a pending state for 24 hours before a reminder is sent to the Case Management team for follow-up with the healthcare provider.
- Once all details are correct and complete, the form will be forwarded instantly to Case Managers.
- Cases will be attended to as soon as possible, with priority given to new cases, followed by regimen changes, and then follow-up cases.
- Members requiring psychological assessment and support should be referred to the psycho-social support professionals.
- Treatment letters will be sent to the treating doctor immediately once medications are authorised.
- ART medicines will be approved in line with ART Guidelines, MOHSS requirements, benefit guides, and fund rules.
- By agreeing to these terms and conditions, the member confirms acceptance of the treatment protocols under this Programme.
- Email the completed forms, relevant baseline blood results, and the prescription to mhsp@methealth.com.na

*This form is subject to renewal after 12 months.

B. Patient's Personal and Clinical Details*

Surname

First Names

Gender M F Date of Birth 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

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

21. Other chronic conditions the member diagnosed with or treated for:

Diabetis Hypertension Hyperlipidemia Epilepsy Mental illness
 CKD COPD/Asthma Chronic Hepatitis B TB
 Cancer (specify) _____ Other(s), specify _____

22. Opportunistic Infections Yes No If yes, specify _____

23. Exposed to HIV medications before? Yes No Was ART stopped? Yes No When? D D M M Y Y

24. Reasons for RX discontinuation: Side effects Resistance Cost Default Others
 (specify) _____

25. Revised clinical staging and immunological classification of HIV-related disease in adults and children

Clinical Stage 1

Asymptomatic Persistent generalised lymphadenopathy (PGL)

Clinical Stage 2

Moderate unexplained weight loss of presumed or measured body weight Herpes zoster
 Recurrent respiratory tract infections (RTIs, sinusitis, bronchitis, otitis media, pharyngitis) 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) 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 (Oral/labial, 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 Medications and Strengths (discontinued regimen)	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	
Primary ICD code		D	D	M	M	Y	Y	
Co-morbidity 1 ICD code		D	D	M	M	Y	Y	
Co-morbidity 2 ICD code		D	D	M	M	Y	Y	
Co-morbidity 3 ICD code		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. 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
---	---	---	---	---	---

You will be notified of the outcome by email.