



## Section C: Clinical information

Date of HIV diagnosis

In the past 24 months was the patient diagnosed with TB?  Yes  No

If yes, date TB treatment started           TB treatment end date

Drug resistant TB  Drug sensitive TB  Unknown

Has the patient been diagnosed with TB Meningitis?  Yes  No

Does the patient have an active psychiatric disease?  Yes  No

If yes, with depression?  Yes  No

Cryptococcal Meningitis?  Yes  No

Has the patient diagnosed or tested for chronic renal disease?  Yes  No

If patient is between 15-19 years a urine dipstick is required  Normal  Abnormal  Proteinurea  Yes  No

Previous ART (excluding PMTCT)?  Yes  No

Previous ART for PMTCT?  Yes  No

Currently on ART?  Yes  No

Is this a test and treat enrolment?  Yes  No

Allergies: \_\_\_\_\_

OTHER CHRONIC CONDITION(S)	CHRONIC MEDICATION REGISTRATION	YES	NO	GEMS DMP ENROLMENT	YES	NO

WHO Stage:  1  2  3  4

### SYMPTOMS EXPERIENCED BY PATIENT OVER PAST SIX MONTHS

WHO CLINICAL STAGE 3 SYMPTOMS	WHO CLINICAL STAGE 4 SYMPTOMS
Unexplained severe weight loss (>10% of body weight)	HIV wasting syndrome
Unexplained chronic diarrhoea > one month	Pneumocystis pneumonia
Unexplained persistent fever > one month	Recurrent severe bacterial pneumonia
Persistent oral candidiasis	Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)
Oral hairy leukoplakia	Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
Pulmonary tuberculosis	Extrapulmonary tuberculosis
Severe bacterial infections (e.g. pneumonia)	Kaposi's sarcoma
Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis	Cytomegalovirus infection (retinitis or infection of other organs)
Unexplained anaemia, neutropaenia, chronic thrombocytopenia	Central nervous system toxoplasmosis
<b>Clinical Stage 3 – Paediatric</b>	HIV encephalopathy
Unexplained moderate malnutrition	Extrapulmonary cryptococcosis including meningitis
Unexplained persistent diarrhoea (14 days or more)	Disseminated non-tuberculous mycobacteria infection
Persistent fever > one month	Progressive multifocal leucoencephalopathy
Persistent oral candidiasis (after first six weeks of life)	Chronic cryptosporidiosis
Acute necrotizing ulcerative gingivitis or periodontitis	Chronic isosporiasis
Lymph node tuberculosis	Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)
Weakness, numbness or paraesthesia in hands or feet	Recurrent septicaemia (including non-typhoidal salmonella)

**PMTCT**Estimated date of delivery **PEP**Date of incident Type of exposure  Sexual exposure  Blood exposure**PrEP**Reason\*  Discordant couple  MSM (men who have sex with men)  Anal or unprotected vaginal sex in the past 6 months Sexual partner who is HIV positive  Inconsistent use of condoms  Diagnosed with a STD in the past 6 months IDU (intravenous drug user)  Shares needles, syringes and/or other injection equipment  Multiple courses of PEPConfirmation of HIV-positive partner reviewed by practitioner  Yes  NoIs HIV-positive partner on GEMS?  Yes  No Membership no. **Section D: Measurements and pathology**Weight  kgHeight  cm**LATEST HIV PATHOLOGY RESULTS (COMPLETE OR ATTACH RESULTS)**

TEST	DATE								RESULT
CD4 cell count*	Y	Y	Y	Y	M	M	D	D	/mm3
CD4 % (child <12 years)	Y	Y	Y	Y	M	M	D	D	%
VL*	Y	Y	Y	Y	M	M	D	D	copies/ml

**OTHER RESULTS**

TEST	DATE								RESULT	
RPR	Y	Y	Y	Y	M	M	D	D	Pos:	Neg:
Hep B sAg	Y	Y	Y	Y	M	M	D	D	Pos:	Neg:
Hb	Y	Y	Y	Y	M	M	D	D	g/dl	
Creatinine*	Y	Y	Y	Y	M	M	D	D	mMol/l	
eGFR*	Y	Y	Y	Y	M	M	D	D		
TB sputum	Y	Y	Y	Y	M	M	D	D	Pos:	Neg:
PAP smear	Y	Y	Y	Y	M	M	D	D		
ALT	Y	Y	Y	Y	M	M	D	D		
U&E – Pt on tenofovir	Y	Y	Y	Y	M	M	D	D		
LFT – Pt on nevirapine	Y	Y	Y	Y	M	M	D	D		
FBC – Pt on zidovudine	Y	Y	Y	Y	M	M	D	D		

## Section E: ART information

### PREVIOUS ANTI-RETROVIRAL THERAPY (ART) AND HIV-RELATED PROPHYLAXIS

MEDICINE	DOSE	DATE COMMENCED								DATE STOPPED								REASON STOPPED/ SIDE-EFFECTS
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

### CURRENT ART, PROPHYLAXIS AND CHRONIC MEDICINE

MEDICINE	DOSE	DATE COMMENCED								DATE STOPPED								REASON STOPPED/ SIDE-EFFECTS
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

Keep current ARTs?  Yes  No If no, indicate new ARTs on the following page.

### NEW ART, PROPHYLAXIS AND CHRONIC MEDICINE

MEDICINE	DOSE	DATE COMMENCED								DATE STOPPED								REASON STOPPED/ SIDE-EFFECTS
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

### PMTCT: ART FOR BABY, PROPHYLAXIS AND CHRONIC MEDICINE

MEDICINE	DOSE	DATE COMMENCED								DATE STOPPED								REASON STOPPED/ SIDE-EFFECTS
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	
		Y	Y	Y	Y	M	M	D	D	Y	Y	Y	Y	M	M	D	D	

**PLEASE NOTE:** Include a prescription for the medicine recommended for treatment.

**ATTACHMENTS:** Copies of the following must be attached to this application.

Confirmation of HIV status (ELISA)  CD/Viral load result/Hb/ALT/CREATININE  Prescription for medicine recommended

- I certify that the above particulars are to the best of my knowledge accurate.
- I confirm that I have disclosed the results to the member and have given the required counselling including the importance of adhering to the treatment plan, which includes regular follow-ups and medicine compliance.
- I hereby authorise GEMS to process and submit a claim for payment under tariff code 0199 on my behalf, as reimbursement for completing this registration form. I confirm that I will not submit a separate claim. NB: Tariff code 0199 will only be paid for first time completion of the registration form.

Doctor's signature \_\_\_\_\_

Date 

D	D	M	M	Y	Y	Y	Y
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\*These fields are required to complete the enrolment on the HIV/AIDS DMP.

Please fax the completed form to **0800 436 7329** or email to **hiv@gems.gov.za**