Pick n Pay
Medical scheme

pha
PRIVATE HEALTH ADMINISTRATORS

CONFIDENTIAL HIV REGISTRATION FORM - CHILD

Page 1 - Routine requirements for the new registration.
Page 2-3 - To be completed and signed by the member, the signature is essential in order to process this Confidential application.
Page 4-7 - To be completed by the treating doctor

Routine requirements for the new registration

Description	Tariff	Tickbox
CD4 Count and CD4%	3816	
Viral load and log value	4429	
F.B.C.	3755 + 3796	
AST	4130	
ALT	4131	
Serum Creatinine	4032	
Serum Urea	4151	
Serum Random Glucose	4057	
Serum Random Cholesterol	4027	
Hepatitis B Immunity (H306)	4531	
Other relevant results /information.		
Urine dipstick		
Vital Signs (Pulse / Temperature)		
Weight and Height		
Clinical findings on physicalexamination such as palpable liver/ enlarged spleen		

Please fax or email the completed forms and additional requirements to our CONFIDENTIAL contact details as below.

Telephone: 0860 767633 (option 5)
Fax: 0866 620 282
E-Mail: pnpcare@pha.co.za

Page 2 - 3 to be completed by the Parent / Guardian

Details of patient/child	
Membership number	
Preferred telephone number	
for Confidentiality.	
Would you like to receive	
information via SMS	
Confirm the cell number	
D.O.B.	
Parent or Guardian details	
Relationship to the child	
Surname	
First Name/	
Preferred Name	
D.O.B	
Please provide us with your contact details in the spaces blow so that we can keep in touch.	
Home phone	
Work phone	
Department or extension number	
Cell phone	
Fax number	
E-mail	
Postal address	
Residential address	
Other information	
When is the best time to call?	
Preferred telephone number for Confidentiality.	
Would you like to receive information via SMS	
Confirm the cell number	
Are you the person responsible to care for the child on a daily basis? (Yes or No)	
IF NO give us details of the Care giver on next page	

Details of Child's care giver	
Relationship to the child	
Surname	
Name/s	
Preferred name	
Tel number home	
Tel umber work	
Cell phone	
Residential address	
Is the care giver aware of the child's HIV Status?	
Has the Care giver been educated regarding the child's daily care and medication?	

I/we understand that personal clinical information is necessary to determine benefits required to manage the treatment of HIV Positive beneficiaries. I /we therefore consent to the disclosure of this information by any medical service provider in possession of any medical information regarding myself to my Scheme or Private Health Administrators. My scheme and Private Health Administrators may only use such information for managed health care purposes and may not disclose such information to any other person without my consent.

I understand that the benefits authorised by the Professional nurse who works at the Scheme are subject to SCHEME RULES and that NON-COMPLIANCE to the programme may result in my benefits under the programme being cancelled.

GUARDIANS SIGNATURE ____

DATE ___________________

ALL THE INFORMATION YOU GIVE US WILL BE KEPT STRICLY CONFIDENTIAL AND WILL NOT BE SHARED WITH ANYONE OTHER THAT THE TREATING DOCTORS / NURSES AND PHARMACY WITHOUT YOUR PERMISSION.

Page 4-7 to be completed by Doctor

MEMBERS NAME	
MEMBERS NUMBER	

DOCTORS DEATILS	
Title	
Surname	
First names/s	
Practice number	
Telephone	
Fax	
Cell Phone	
E-mail	
Postal Address	
Rooms/Physical Address	
CLINICAL ASSESSMENT OF PATIENT	
Date diagnosed	
Reason for testing	
Vital signs	
Temp	
Weight	
Height	
Head	
Circumferance	

WHO CLINICAL STAGING IN CHILDREN	
CLINICAL STAGE 1	
• Asymptomatic	
• Persistent generalised lymphadenopathy	
CLINICAL STAGE 2- MILD SYMPTOMS	
• Unexplained persistent hepatosplenomegaly	
• Papular pruritic eruptions	
• Extensive wart Virus infection	
• Extensive molluscum contagiosum	
• Fungal nail infections	
• Recurrent oral ulcerations	
• Unexplained persistent parotid enlargement	
• Lineal gingival erythema	
• Herpes zoster	

CLINICAL STAGE 3 – MODERATE SEVERITY	
• Unexplained moderate malnutrition not adequately responding to standard therapy	
• Unexplained persistent diarrhoea (14 days or more)	
• Unexplained persistent fever (above 37.5°C intermittent or constant for longer than one month)	
• Persistent oral candidiasis (after 6 weeks of life)	
• Oral hairy leukoplakia	
• Acute necrotizing ulcerative gingivitis or periodontitis	
• Lymph node tuberculosis	
• Pulmonary Tuberculosis	
• Severe recurrent bacterial pneumonia	
• Symptomatic lymphoid interstitial pneumonitis	
• Chronic HIV – associated lung disease including bronchiectasis	
• Unexplained anaemia (<8g/dL), neutropaenia (<0.5 x 109 per litre)	
• And /or chronic thrombocytopaenia (<50 x 109 per litre)	

CLINICAL STAGE 4 – SEVERE	
• Unexplained severe wasting. Stunting or severe malnutrition not responding to standard therapy	
• Pneumocystis pneumonia	
• Recurrent severe bacterial infections (such as empyema,pyomyositis, bone or joint infection or meningitis but excluding pneumonia)	
• Chronic herpes simplex infection (orolabial or cutaneous of more than one month's duration or visceral at any siute)	
• Extra pulmonary tuberculosis	
• Kaposi sarcoma	
• Oesophageal candidiais (or candidiasis of trachea, bronchi or ungs)	
• Central nervous system toxoplasmosis.	
• HIV encephalopathy	
• Cytomegalovirus infection: retinitis or cytomegalovirus infection affecting another organ, with onset at age older than 1 month	
• Extra-pulmonary cryptococcosis (including meningitis)	
• Disseminated endemic mycosis (extra-pulmonary histoplasmosis, coccidiomycosis)	
• Chronic cryptosporidiosis	
• Chronic isosporiasis	
• Disseminated non-tuberculous myobacterial infection	
• Cerebral or ß-cell non-Hodgkin lymphoma	
• Progressive multifocal leukoencephalopathy	
• Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy	
• HIV-associated rectovaginal fistula	

Reference: The Aurum Institute Version 1 June 2012

	RESPONSES
Is there any degree of peripheral neuropathy? (YES or NO)	
If YES please specify where ?	
Severity : (MILD / MODERATE / SEVERE)	
Has the child been tested for TB (YES or NO)	
If NO. Confirm that you do not suspect the child to be T.B. positive.	
If YES Test result = Positive or Negative	
Date	
Type/ Site	
Treatment	
Drugs	
Date started	
Date ended	
Duration in months	
Is there any other significant clinical finding and or concern? (YES or NO)	
If YES please specify.	
Does the child suffer from any other CO-MORBIDITIES? (YES or NO)	
If YES – Please specify.	

PATHOLOGY RESULTS / HISTORICAL DATA			
Pathology	Date	Result	Comment

ARV/ HAART TREATMENT HISTORY

PREVIOUS TREATMENT WITH ARV / and Prophylaxis = complete table below.				
Date	Name of Medication	Dosage	Reason for starting ARV	Comment

TREATMENT NAÏVE

Has the Guardian or Caregiver received counselling and expressed willingness and readiness to care for this child and ensure that they will give medication as instructed?

Yes ☐ No ☐

CURRENT TREATMENT REQUESTED = ATTACH A VALID SCRIPT

Please send us a SCRIPT of the treatment you would like the child to receive.
The script can only be authorised if:
• Application form has been signed by the Parent/Guardian
• If all baseline requirements are met.

SIGNATURE OF TREATING DOCTOR: ___________________________________ DATE: ___________________

OTHER INFORMATION

The HIV RISK Manager/ Case manager will provide counselling and support to encourage maximum adherence to treatment to ensure optimal outcome.

- The authorisation for the programme, auth for HAART for the child as well as the treatment plan for the ongoing management will be sent to the treating doctor in writing.
- Should you as the treating doctor need further information or if you would like to discuss the case, please feel free to contact us on:

Telephone: 0860 767633 (option 5)
Fax: 0866 620 282
E-Mail: pnpcare@pha.co.za

PLEASE SEND THE COMPLETED FORM AND A SCRIPT TO NUMBERS DETAILED ABOVE.