Aid for Aids
Your life. Our life.

nhp™
We're about you

Aid for AIDS (AfA) Programme application Confidential

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Reg No: MOHSS 003

The Aid for AIDS (AfA) Programme has its own administration, and is kept strictly confidential in order to reassure members that his/her status will remain confidential at all times.

Please note Print clearly using **capital** letters, only **one** character per block. Leave **one** block open between words and mark with an **X** where necessary. Attach all supporting documents. To be completed by applicant. Treatment support is a vital part of the AfA Programme. Please fax completed form where possible to fax 061 271 674.

Particulars of patient (must be completed)

Please note Contact details must be supplied to enable us to provide you with this support.

Membership number | Benefit option

Title | Initials | First name(s)

Surname

Nationality of passport | ID/Passport number | Dependant code

Date of birth (D D M M Y Y Y Y) | Gender | Occupation

Tel (H) | Tel (W)

Cell | Fax

Email

Postal address of choice for **confidential** mail | Postal code

What time of day is the best time for AfA to contact you? ☐ Morning ☐ Afternoon

What is your first language?

What is your second language?

Contact information of caregiver if minor is in care of someone else, other than parents (should know your HIV status)

Relationship to patient

Title | Initials | First name(s)

Surname

Tel (H) | Tel (W)

Cell

Section 1 Clinical history

Please note *Sections 1 to 6* ***must*** *be completed by a registered healthcare provider.* ***All*** *questions below must be answered with a* ***yes or no****. If yes, please provide further detail in the appropriate spaces.*

When was the HIV infection first diagnosed? (please attach reports)

Type of screening test _____ *Date* D D M M 2 0 Y Y

Is the patient currently being treated for tuberculosis? ☐ *Yes* ☐ *No*

If yes, start date? D D M M 2 0 Y Y

Has the patient previously been exposed to antiretrovirals? ☐ *Yes - MTCT Prophylaxis* ☐ *Yes - Other* ☐ *No*

If yes, please provide details of previous antiretroviral exposure _____

Please note ***ART history*** *- Only for patients being registered on the AfA Programme.*

Drug	Date treatment started	Date treatment ended	Duration (months)	Reason for discontinuation

Give the current combination the patient is taking _____

Please list all other medication the patient is taking, including prophylaxis, traditional and herbal remedies

Is the patient allergic to any medication? ☐ *Yes* ☐ *No*

Sulphonamides ☐ *Yes* ☐ *No*

Other allergies ☐ *Yes* ☐ *No*

Please specify medication _____

Section 2 Information required to prevent adverse side-effects of certain drugs

Is there a history of heavy alcohol intake? (i.e. more than 4 drinks per day for a long period of time) ☐ *Yes* ☐ *No*

Is there a history of recreational drug use? (e.g. cannabis, cocaine, ecstasy, LSD etc.) ☐ *Yes* ☐ *No*

Is there a history of any depression or a psychiatric illness? ☐ *Yes* ☐ *No*

If you have answered yes to any of the above questions, please specify _____

Section 3 Clinical examination

Please note *Weight and height* ***must be completed*** *to calculate the correct dosage.*

Weight (without shoes) _____ *kg* *Height (without shoes)* _____ *cm*

Women only

Are you pregnant? ☐ *Yes* ☐ *No* *If pregnant, expected date of delivery* D D M M 2 0 Y Y

Expected mode of delivery ☐ *NVD* ☐ *C/S* *Expected date for c-section* D D M M 2 0 Y Y

Section 4 WHO clinical staging (please indicate disease below stage 3 or 4)

Stage ☐ *1* ☐ *2* ☐ *3* ☐ *4*

Clinical Stage 1

Generalised Lymphadenopathy ☐ *Yes* ☐ *No*

Clinical Stage 2

Unexplained severe weight loss (>10% of body weight) ☐ *Yes* ☐ *No*

Unexplained persistent fever > 1 month ☐ *Yes* ☐ *No*

Minor mucocutaneous conditions ☐ *Yes* ☐ *No*

Pulmonary tuberculosis	☐ *Yes*	☐ *No*
Shingles within the last 5-years	☐ *Yes*	☐ *No*
Unexplained anaemia, neutropaenia, chronic thrombocytopaenia	☐ *Yes*	☐ *No*

Clinical Stage 3

Unexplained persistent diarrhoea > 1 month	☐ *Yes*	☐ *No*
Unexplained persistent fever > 1 month	☐ *Yes*	☐ *No*
Persistent oral candidiasis (after first 6 weeks of life)	☐ *Yes*	☐ *No*
Severe bacterial infections (e.g Pneumonia)	☐ *Yes*	☐ *No*
Oral hairy leukoplakia	☐ *Yes*	☐ *No*
Acute necrotizing ulcerative gingivitis/periodontitis	☐ *Yes*	☐ *No*

Clinical Stage 4

HIV wasting syndrome (see clinical guidelines for definitions)

Is there any degree of peripheral neuropathy?		☐ *Yes*	☐ *No*
If yes, please specify	☐ *Mild*	☐ *Moderate*	☐ *Severe*
Is there any other significant clinical finding?		☐ *Yes*	☐ *No*

If yes, please specify _____

Section 5 *Special investigation results*

Please note *Please provide copies of reports. Please supply as many results as possible, including baseline results. Approval for ongoing antiretroviral therapy will only be considered if the result and date of a recent CD4 count and viral load is supplied. Only medication recommended in the Aid for AIDS Clinical Guidelines will be considered for reimbursement. Please refer to these guidelines or contact Aid for AIDS on tel 061 285 5423 or at info@afa.com.na for further information. Motivations will however always be considered. Please contact AfA Programme for assistance if required.*

Date test performed	***CD4 count*** *(cells/mm)*	***CD4 %*** *(must be provided for children)*	***Viral load*** *(copies/ml)*
D D M M 2 0 Y Y			
D D M M 2 0 Y Y			
D D M M 2 0 Y Y			
D D M M 2 0 Y Y			

Additional investigations	***Test done***		***Date test performed***	***Results***
Blood count(s) (essential prior to approval of zidovudine)	☐ *Yes*	☐ *No*	D D M M Y Y	
Baseline ALT (essential prior to approval of nevirapine)	☐ *Yes*	☐ *No*	D D M M Y Y	
Serum creatinine/eGFR (essential for patients with renal failure or prior approval of Tenofovir)	☐ *Yes*	☐ *No*	D D M M Y Y	

Section 6 *Medication*

Please note *Generic equivalents and fixed dose combination tablets will be authorised unless otherwise stated.*

Antiretroviral therapy	***Strength*** *(e.g. 10mg)*	***Directions*** *(e.g. 1 tds*)*	***Period in use*** *(months)*	***Period required*** *(months)*

Other medication required - associated with the management of HIV

Diagnosis	***Strength*** *(e.g. 10mg)*	***Directions*** *(e.g. 1 tds*)*	***Period in use*** *(months)*	***Period required*** *(months)*

Particulars of doctor/specialist (who will be providing ongoing care)

Title | Initials | First name(s)

Surname

Practice number

Tel (W) | Fax

Email

Postal address | Postal code

Examining doctor/specialist acknowledgment and declaration

I certify that the above particulars are – to the best of my knowledge and belief – true and accurate, having conducted a personal examination and procured the tests and/or other diagnostic investigations referred to. I confirm that I have counselled the patient on the importance of adhering to medication and monitoring test regimens. I acknowledge that the AfA Programme will rely on such particulars when making any recommendations regarding payment for treatment to the relevant medical fund. I acknowledge that telephonic discussions will be taped for medico-legal purposes.

Signature of doctor/specialist

D D M M 2 0 Y Y

Date

Practice stamp

Patient acknowledgment and declaration

I understand that all personal clinical information supplied to the AfA Programme will be used to determine access to specific benefits for people with HIV. AfA will take all reasonable steps to maintain confidentiality. The programme's medical staff will review this information in order to make recommendations regarding the provision of these benefits. Your doctor, however, retains responsibility for your care, irrespective of the benefits so authorised.

I/we therefore, authorise any doctor, hospital, clinic, laboratory and/or medical facility in possession of any medical information regarding myself, the applicant or any dependant (also newly born baby), to provide the AfA Programme with information that it may require. I warrant that the information in this application form is correct.

I understand that acceptance onto AfA Programme means that an AfA treatment support counsellor will contact me. I herewith authorise AfA and its agents or medical staff to disclose the medical information relevant to my HIV infection to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.

Signature of patient

D D M M 2 0 Y Y

Date