UMVUZO HEALTH

rx health
an UMVUZO HEALTH Partner

HIV DISEASE MANAGEMENT PROGRAMME REGISTRATION

This registration form should be used for Umvuzo Health Members.

1. Please complete one registration form per beneficiary.
2. Please complete the registration form in black pen for legibility.

General

1. Submit the script and any available pathology results with the registration form.
2. Remember that the script must be renewed every six months.
3. For telephonic questions or support, please phone the case manager on 0861 083 084.
4. Please return form to **fax:** 086 685 9709 / **post:** PO Box 90346, Garsfontein, 0042 / **email:** chronic@rxhealth.co.za.

HEALTH CARE PROFESSIONAL'S DETAILS

Doctor		Practice number	
Contact details	Tel	Fax	
	Cell	Email	

PATIENT DETAILS

Gender	Male		Female	Age	
Surname					
First name					
Tel		Cell			
Identity number					
Medical scheme	Umvuzo Health	Option			
Member number		Dep code			

PREVIOUS HISTORY

Date of diagnosis (year) Y Y Y Y

Previous HIV-related illnesses/hospitalisation

1 | Year Y Y Y Y | 2 | Year Y Y Y Y

Other chronic illnesses/hospitalisation

1

2

ART STATUS

No previous ART		Previous ART (specify)			
PMTCT		Year Y Y Y Y	Regimen		
ART/Prophylaxis		Year Y Y Y Y	Regimen		
1 Treatment started Y Y Y Y	Date changed Y Y Y Y	or	Date stopped Y Y Y Y		
Starting CD4 cell count					

Member number		Dep code	

HIV DISEASE MANAGEMENT PROGRAMME REGISTRATION

2	Changes in ART (tick boxes)	Allergic reaction		Side effects		Treatment simplification	
	Other (specify)						
	Current ART regimen			Date started	Y Y	Y Y	

CLINICAL ASSESSMENT

Weight	kg	Height	m

Patient's general appearance	Fit		Frail		Chronically ill	

Sulphonamides allergies	Y	N	Any other allergies	Y	N	

Is the patient to your knowledge generally compliant with medication?	Y	N

Has your patient been investigated or treated for TB?	Y	N	TB treatment started	Y Y	Y Y

Isoniazid-preventive therapy done prior to starting ART?	Y	N

Co-morbid conditions	Hypertension		Diabetes type 1		Diabetes type 2		Hyperlipidaemia	

Treatment for the above	

Has the patient received any of the following vaccines?

HPV	Y	N	Meningococcal	Y	N	Hep A	Y	N	Influenza	Y	N
Yellow fever	Y	N	Pneumococcal	Y	N	Hep B	Y	N	Other vaccinations		

ANY PATHOLOGY RESULTS (PLEASE ATTACH)

SOCIAL HABITS

Smoking	Y	N	How many years			Number per day			
Alcohol use	Y	N	Social			Regular			
Regular exercise	Y	N							

DIAGNOSED OR TREATMENT FOR THE FOLLOWING CONDITIONS

Oral candidiasis	Y	N	Pneumocystis pneumonia	Y	N
Oesophageal candidiasis	Y	N	Shingles	Y	N
Pulmonary tuberculosis	Y	N	Dermatitis	Y	N
Extra pulmonary tuberculosis	Y	N	Kaposi sarcoma	Y	N
Significant lymphadenopathy	Y	N	Peripheral neuropathy	Y	N
Significant weight loss › 10%	Y	N	Chronic diarrhoea	Y	N
Recent hospital admission	Y	N	Skin conditions	Y	N
Psychiatric conditions	Y	N	Depression	Y	N

Member number		Dep code	

HIV DISEASE MANAGEMENT PROGRAMME REGISTRATION

OBSTETRIC HISTORY

Gravida		Para		Planning to become pregnant?	Y	N
Contraception used	Oral		Injectable		Barriers		IUD	
Is the patient pregnant?	Y	N	Date of delivery	Y Y Y Y M M D D				
Expected mode of delivery	NVD		Caesarean		(Caesarean section suggested)			

LEGAL DECLARATION

I the undersigned, (name and surname) _____
declare that I have received individual counselling and education on HIV/AIDS in a language that I understand, and that I am able to make an informed decision to register for the HIV Disease Management Programme of Rx Health, the contracted managed health care organisation of Umvuzo Health.

I understand that Rx Health must access my personal information to make recommendations about my treatment needs and to provide me with the full benefits of the HIV Disease Management Programme.

I authorise any third party, previous scheme or health care professionals, for example, pathology laboratories, doctors, pharmacies and hospitals, in possession of any medical information about me or my dependants (if minor) to provide it to Rx Health to assist in the provision of my care. I acknowledge that my health care professional will request for pathology tests for the ongoing monitoring, clinical management and treatment of my conditions.

I understand that the pharmacies and service providers are bound by the ethical and legal guidelines of health care professionals to protect my information.

Patient signature _____ Date Y Y Y Y M M D D

(legal guardian for a minor)

Treating Provider signature _____ Date Y Y Y Y M M D D

Practice Number _____

ADDRESS FOR DELIVERY OF MEDICINE

Address							
Telephone (home)		Telephone (work)					
Cell							
Indicate preferred contact method	Home		Work		Cell		
Convenient time of day	Any time		Morning		Afternoon		Evening	

Please notify us immediately if you change your contact details.

WHAT DO YOU RECOMMEND FOR YOUR PATIENT?

Patient additional counselling and support	Y	N
Patient is ready for treatment	Y	N

Do you have any comments for Rx Health? _____

_____

_____

_____

_____

_____

_____