momentum

Health4Me HIV benefit application form

Important notes:

- Please submit the completed and signed form via email to **health4mehiv@momentum.co.za**.
- For assistance call us on 0860 55 56 09.

1: Patient's details

Membership number

Member name

Member surname

Dependant code

Gender Male Female

ID number

Date of birth D D M M Y Y Y Y

Passport number

Passport country of origin

Contact number

Email address

2: Patient consent (to be signed by the member or guardian if the patient is a minor)

2.1 I hereby confirm that the information provided in this application is true and correct.

2.2 I acknowledge that Momentum Health (Pty) Ltd is the administrator of the HIV benefit programme and that any antiretroviral treatment prescribed, as well as the general management of my HIV condition, shall be the sole responsibility of my medical practitioners. Momentum Health (Pty) Ltd and my employer shall not be liable for any claims by me or my dependants arising from the implementation of the programme, where Momentum Health (Pty) Ltd was not negligent in executing its responsibilities.

2.3 I hereby give my consent to Momentum Health (Pty) Ltd and its staff to obtain my personal information (ie health and biometric) from my healthcare providers (medical doctor, pharmacy, pathology and radiology) to assess my medical risk and to enrol me on the programme, using such information to my benefit. I understand and agree that special personal information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological or financial analysis, without disclosure of my identity.

2.4 I understand that no information regarding my case will be made available to my employer or any other person not directly involved in my care.

2.5 Whilst Momentum Health (Pty) Ltd undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed, I am aware that Momentum Health (Pty) Ltd, my employer and healthcare providers shall also gain access to the same information.

2.6 I shall be entitled to terminate my participation in the programme at any time with immediate effect, but understand that the consequences of such a decision will rest with me alone.

2.7 I understand that calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the HIV benefit department.

2.8 I acknowledge that my details provided above are treated as confidential and I accept that the HIV benefit programme may use these contact details to communicate with me.

Member/guardian signature **Date** D D M M Y Y Y Y

3: Doctor's details and consent

Practice number

Doctor's name

Doctor's surname

Telephone number

Email address

I confirm that the clinical details described in this document are, to my knowledge, accurate and correct. I understand the HIV benefit treatment protocols are guidelines only, and that the ultimate responsibility regarding antiretroviral therapy and general management of my patient's condition will reside with me. The reimbursement of therapy and related costs by Momentum Health (Pty) Ltd will be in accordance with the guidelines, as well as the benefit available to the above patient from time to time.

Doctor signature **Date** D D M M Y Y Y Y

4: Clinical information

Date of HIV diagnosis D D M M Y Y Y Y

Is the patient pregnant? Yes ☐ No ☐ Estimated date of delivery D D M M Y Y Y Y

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

If yes, TB treatment dates: TB treatment start date D D M M Y Y Y Y TB treatment end date D D M M Y Y Y Y

Does the patient have drug resistant TB? Drug sensitive TB ☐ Unknown ☐

Does the patient have an active psychiatric disease? Yes ☐ No ☐

If yes, with depression? Yes ☐ No ☐ Cryptococcal meningitis? Yes ☐ No ☐

Has the patient been tested for chronic renal disease? Yes ☐ No ☐

If the patient is between 15-19 years, a urine dipstick is required Normal ☐ Abnormal ☐ Proteinuria ☐

Previous ART exposure (excluding single dose NVP)? Yes ☐ No ☐

Currently on ART Yes ☐ No ☐ If yes, first date ART was started D D M M Y Y Y Y

Does the patient have allergies? Please specify Yes ☐ No ☐

Any medical or surgical conditions? Please specify Yes ☐ No ☐

WHO stage 1 ☐ 2 ☐ 3 ☐ 4 ☐

Symptoms experienced over the past 6 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	☐
Pulmonary tuberculosis	☐	Extrapulmonary tuberculosis	☐
Severe bacterial infections (eg pneumonia)	☐	Kaposi's sarcoma	☐
Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis	☐	Cytomegalovirus infection (retinitis or infection of other organs)	☐
Unexplained anaemia, neutropenia, chronic thrombocytopaenia	☐	Central nervous system toxoplasmosis	☐
Clinical stage 3 - Paediatric	☐	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 leukoencephalopathy	☐
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)	☐
Oral hairy leukoplakia	☐	Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)	☐
Persistent oral candidiasis	☐	Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)	☐

5: Latest pathology (Please complete or attach results)

Test name	Tariff code	Date	Result	
Elisa	3 9 3 2	Y Y Y Y M M D D		
CD4 cell count*	3 8 1 6	Y Y Y Y M M D D		/mm3
CD4 % (child < 12 years)*	3 8 1 6	Y Y Y Y M M D D		%
Viral load*	4 4 2 9	Y Y Y Y M M D D		copies/ml
Hep B sAg	4 5 3 1	Y Y Y Y M M D D	Pos:	Neg:
Creatinine*	4 0 3 2	Y Y Y Y M M D D		mMol/l
eGFR	4 0 3 2	Y Y Y Y M M D D		
TB sputum	3 8 8 1	Y Y Y Y M M D D	Pos:	Neg:
	3 8 8 7	Y Y Y Y M M D D	Pos:	Neg:
AST*	4 1 3 0	Y Y Y Y M M D D		

5: Latest pathology (Please complete or attach results) (continued)

Test name	Tariff code	Date	Result
ALT*	4 1 3 1	Y Y Y Y M M D D	
U&E*	4 1 7 1	Y Y Y Y M M D D	
LFT	4 1 3 3	Y Y Y Y M M D D	
FBC	3 7 5 5	Y Y Y Y M M D D	
Hb	3 7 6 2	Y Y Y Y M M D D	

*Mandatory test

6: ART information

Previous antiretroviral therapy (ART)

Medicine	Dose	Date commenced	Date stopped	Reason stopped/side-effect
		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 antiretroviral therapy (ART) and chronic medicine

Medicine	Dose	Date commenced	Date stopped	Reason stopped/side-effect
		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 antiretroviral therapy (ART)? Yes ☐ No ☐

New antiretroviral therapy (ART) requested

Medicine	Dose	Date commenced
		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

7: Medical history

Please provide details of the patient's significant medical history, including opportunistic infections

	Date	Duration	Treatment received	Outcome
Operation/hospital admissions (especially if related to HIV infection)				
Illnesses				