





8. WHO staging

1  2  3  4

**Section D: Test results**

1. CD4 count and percentage

| Date |   |   |   |   |   |   |   |   |   | Results |
|------|---|---|---|---|---|---|---|---|---|---------|
| D    | D | - | M | M | - | Y | Y | Y | Y |         |
| D    | D | - | M | M | - | Y | Y | Y | Y |         |
| D    | D | - | M | M | - | Y | Y | Y | Y |         |
| D    | D | - | M | M | - | Y | Y | Y | Y |         |

2. Viral load

| Date |   |   |   |   |   |   |   |   |   | Results |
|------|---|---|---|---|---|---|---|---|---|---------|
| D    | D | - | M | M | - | Y | Y | Y | Y |         |
| D    | D | - | M | M | - | Y | Y | Y | Y |         |
| D    | D | - | M | M | - | Y | Y | Y | Y |         |
| D    | D | - | M | M | - | Y | Y | Y | Y |         |

3. Please list other abnormal copy of results

|  |
|--|
|  |
|  |
|  |

4. Antiretroviral and prophylactic medication requested

| Name | Dosage |
|------|--------|
|      |        |
|      |        |
|      |        |
|      |        |

5. Previous antiretroviral medication

| Name | Started         | Stopped         | Reason |
|------|-----------------|-----------------|--------|
|      | D D M M Y Y Y Y | D D M M Y Y Y Y |        |
|      | D D M M Y Y Y Y | D D M M Y Y Y Y |        |
|      | D D M M Y Y Y Y | D D M M Y Y Y Y |        |
|      | D D M M Y Y Y Y | D D M M Y Y Y Y |        |

6. Current chronic medication

| Name | Dosage |
|------|--------|
|      |        |
|      |        |
|      |        |
|      |        |

### Section E: Doctor's details (to be completed by the doctor)

|   |                      |                      |                      |                      |                      |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|
| Doctor's last name                        | <input type="text"/> | Initials             | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Practice number                           | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Work telephone (please include area code) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Mobile (please include area code)         | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Email address                             | <input type="text"/> |                      |                      |                      |                      |

### Section F: Declaration by treating doctor

I hereby confirm that I have physically examined the programme applicant and have accurately recorded my findings in this application form. I understand that Libcare or the Administrator may contact me from time to time to request a clinical update including pathology and radiology test results, discuss treatment options and inform me of the programme benefits.

|                    |                      |      |                      |                      |                      |                      |                      |                      |                      |
|--------------------|----------------------|------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Doctor's signature | <input type="text"/> | Date | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|--------------------|----------------------|------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|

### Section G: Declaration by patient

Libcare Medical Scheme and its Administrator, Discovery Administration Services (Pty) Limited ("the Administrator"), are required to collect some of your personal information in order to enrol you in the HIV/AIDS Management Programme. Without your personal information we may be unable to start or continue to provide services to you.

#### Definitions

- **"Personal Information"** means information about an identifiable, natural or juristic person, including but not limited to, information about race, gender, sex, marital status, nationality, ethnic or social origin, colour, sexual orientation, age, physical or mental health, religion, belief, disability, language, birth, education, identity number, telephone number, email, postal or street address, biometric information and financial, criminal or employment history as well as correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence; and
- **"Process"** means any operation or activity, whether automated or not, concerning Personal Information, including: collection; receipt; recording; organisation; collation; storage; updating or modification; retrieval; alteration; consultation; use; dissemination by means of transmission, distribution or making available in any other form; merging, linking, as well as blocking, degradation, erasure or destruction of information. Processing has a similar meaning.

1. I hereby consent to Libcare and the Administrator receiving and requesting my blood test results, radiology and any on-going clinical information pertaining to my health as well as receiving any other information relating to my management on the HIV/AIDS management programme.
2. I also authorise Libcare and the Administrator to collect, process and share my Personal Information to manage my health in terms of the HIV/AIDS Management Programme.
3. I understand that the authorisation applies only for the purposes above and therefore may partially limit my right to privacy.
4. I understand that I am entitled at any time to request access to, update or rectify my Personal Information, through contacting the programme.

Libcare or the Administrator will notify you when your Personal Information has been compromised. We undertake to only process Personal Information as permitted by law. We undertake to keep your Personal Information confidential, secure and only for as long as required and prescribed.

|           |                      |    |                      |                      |   |                      |                      |   |                      |                      |                      |                      |
|-----------|----------------------|----|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| Signed at | <input type="text"/> | on | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|-----------|----------------------|----|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|

|  |                      |
|--|----------------------|
| Signature of Applicant (Guardian/Parent) | <input type="text"/> |
|--|----------------------|