Please fax to 021 441 1677 or email to caseman@careworks.co.za

Enrolment Form

To be completed by DOCTOR

Surname	
Initials and First name	
Practice Number	
HPCSA Number	
Postal Address	
Postal Code	
Physical Address	
Postal Code	
Country	
Email address	
Telephone number	
Cell phone number	
Fax number	

Confidentiality Undertaking

I, the undersigned, Dr ____
hereby contract and agree with CareWorks that all details and information forwarded to me for whatsoever purpose and in whatsoever form (electronic, fax, other) by CareWorks (or its agents) pertaining to a patient under management by CareWorks will remain confidential and shall not be viewed or accessed in any way by unauthorised personnel or 3rd parties. I further warrant that my communications equipment including my fax machine and email account are physically located in a place where they cannot be accessed by unauthorised persons. In this context, "unauthorised persons" does not include my staff who are subject to confidentiality agreements in terms of their employment with me

Signature: ________________________ Date: __________________________

To be completed by PATIENT

Name	
Surname	
Initials	
ID Number	
Date of Birth	
Date of Diagnosis	
Gender (Male/Female)	
Home Language	
Second Language	
Physical Address	
Postal Address	
Telephone number	
Cell phone number	
Medical Aid Name	
Medical Aid Number	
Main Member Initials	

Declaration by patient

I understand that all personal clinical information supplied to the CareWorks programme will be used to determine access to specific benefits for people with HIV infection. The programmes medical staff will review this information in order to make recommendations regarding the provision of these benefits. Your doctor, however, retains responsibility of your care, irrespective of the benefits so authorised.
I therefore authorise the 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 CareWorks programme with information that it may require. I also warrant that the information in this application form is correct. I acknowledge that the benefits authorised by the CareWorks programme are subject to scheme rules and that non-compliance could result in my funding being affected. I understand that acceptance into the programme means that a CareWorks treatment support counsellor will contact me.

Signature: ________________________ Date: __________________________

APPLICATIONS WILL BE REJECTED UNLESS SIGNED BY BOTH THE APPLICANT AND THE DOCTOR

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Enrolment Visit

Date: ____________________

	YES	NO
Are you currently taking medication for TB? If yes, when did you start?		
Have you previously taken meds for TB? If yes, when?		
Do you have a cough that has lasted for more than 2 weeks?		
Do you get soaking wet with night sweats at nights, even when it is not hot?		
Have you lost weight, even though you have not tried to lose weight?		
Have you been hospitalised in the last year? If yes, what for?		
Are you allergic to any medication or environmental allergies? Specify:		
Please list any co-morbid conditions and ICD10 Codes:		

Examination

Age				
Weight (kg)				
Height (m)				
Pregnant?	Yes	No		Other:
If yes, EDD				

	WHO Staging	YES	NO
Stage 1	Persistent Generalised Lymphadenopathy		
	Other:		
Stage 2	Weight loss <10% body weight		
	Recurrent URTI		
	Uncomplicated Herpes zoster		
	Minor mucocutaneous conditions		
	Other:		
Stage 3	Weight loss >10% body weight		
	Oral Candidiasis		
	Oral Hairy Leukopiakia		
	Diarrhoea > 1 month		
	Severe bacterial infections incl. pneumonia		
	Prolonged fever		
	Bedridden <50% / day most of previous month		
	Pulmonary TB within the last year		
	Other:		
Stage 4	Extrapulmonary TB		
	Oesophogeal Candidiasis		
	Herpes simplex lesion > 1 month		
	PCP		
	Kaposi's sarcoma		
	HIV encephalopathy		
	Recurrent pneumonia		
	Cytomegalovirus		
	Isosporiosis / Cryptosporidiosis		
	Bedridden >50% / day most of previous month		
	Other:		

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Special Investigation Results

Please provide copies of reports. Supply as many results as possible including baseline results

Date Test Performed (DD/MM/YYYY)	**CD4 count** (cells/mm)	**CD4%** (Must be provided for children)	**Viral Load** (copies/ml)

Additional Investigations

Blood Count(s) (Essential prior to approval to Zidovudine)			
Test Done?		**If yes, specify results**	**Test Date**
YES	NO		
Baseline ALT (Essential prior to approval of Nevirapine)			
Test Done?		**If yes, specify results**	**Test Date**
YES	NO		
Serum creatinine/eGFR (Essential for patients with renal failure or prior to approval of Tenofovir)			
Test Done?		**If yes, specify results**	**Test Date**
YES	NO		

Medication History (please do not add requests for new ART here)

Category	ICD10	Drug Name	Start (mm/yy)	End (mm/yy)	Reason for stopping
ART					
ART					
ART					
MTCTP					
Other					
Other					

New Prescriptions for ARV's Date: ___________________________

Dr Name and Surname				
Practice Number				
Patient Name and Surname				
Delivery Address				
Pregnant?	YES	NO	N/A	EDD:
ICD10 Codes				

Rx

Repeats:

Signature: ______________________________ Date: ________________________