



Email address

Patient's signature

Date

(If patient is a minor, main member must sign)

### 3. Clinical data and examination (to be completed by the doctor)

More pathology investigations will be useful for a full clinical picture. Please provide copies of the following reports:

CD4 count  Viral load  Full blood count  Liver function test  Urea and creatinine

Is the patient pregnant? Yes  No

If yes, expected date of delivery

Height    cm

Weight    kg

### 4. Other clinical data required (to be completed by the doctor)

Date of diagnosis

4.1 Clinical staging (Centre for Disease Control or World Health Organization)

4.2 Clinical information to substantiate staging in point 1

4.3 Medicine history

Medicine	Duration of treatment	Please insert reason or code (detailed below) for discontinuation of previous antiretroviral therapy

Reason or code for discontinuation: Side effects  Cost  Resistance  Other

If other, please provide a brief explanation

4.4 Is the patient being treated for one or more of the below conditions (please check the appropriate block):

Diabetes  Epilepsy  Hypercholesterolemia  Depression/psychiatric treatment  Tuberculosis (TB)

Cancer  Chronic renal failure  Hypertension/Cardiac failure  Other

4.5 If "other", please provide a brief explanation

4.6 List the medicine the patient is currently taking for the above condition/s (if applicable)

**5. Medicine required for HIV and AIDS (to be completed by the doctor)**

Diagnosis	Date when condition was first diagnosed	Medicine name, strength and dosage	Number of repeats	How long has the patient used this medicine?		May the patient use a generic medicine?	
				Years	Months	Yes	No
HIV							
Opportunistic infections							

Patient's name and surname

Membership number

**6. Treating Doctor's details (to be completed by the doctor)**

Name

BHF practice number  Speciality

Telephone  Cellphone

Email address

I acknowledge that:

1. The approval of this treatment is subject to the HIV status of the patient
2. I have received the patient's consent to disclose their HIV status and any other related information to Engen Medical Benefit Fund and Discovery Health (Pty) Ltd.

Signature of doctor

Date

 Please only sign if information is true, complete and correct.