

APPLICATION - THIRD LINE ANTIRETROVIRAL THERAPY

PLEASE ENSURE ALL FIELDS ARE COMPLETED BEFORE SUBMITTING

Patient First Name							
Patient Surname							
Date of Birth day/month/year				Patient number			
Identity number					Age		Gender
Weight		BMI (kg/m²)		Height (child)			
FACILITY DETAILS							
Facility Name							
Province							
Doctor In Charge Of Patient/ Authorised Prescriber							
Doctor's Contact Number							
Doctor and Pharmacist Email Addresses							
						Date day/month/year	
PAST MEDICATION HISTORY							
Timelines day/month/year		Past Regimens Only		Reason for discontinuation		Concurrent TB therapy?	
Date started							
Date stopped							
Date started							
Date stopped							
Date started							
Date stopped							
Date started							
Date stopped							
Date started							
Date stopped							
<i>Reason for discontinuation codes: SE = Side effect, F= Failure, FC = Formulary change, NC = Non adherent</i>							
CURRENT REGIMEN ONLY							
Date started day/month/year		Regimen					
CHILDREN: PMTCT HISTORY							

Was the mother on therapy during pregnancy or breastfeeding?	
What treatment did the mother take and for how long?	
Was child breastfed?	
Did child receive any ARV at birth/ after birth/ during breastfeeding? State ARV and duration	

ADHERENCE IN LAST 3 – 6 MONTHS

Regular clinic attendance	
On-time pharmacy refill	
Correct pill counts	
Treatment partner observes taking of medication	
Alcohol / drug abuse	
Severe GIT or other side effects experienced	
If adherence problem, what interventions were undertaken to address the issue?	

CD 4 COUNT			VIRAL LOAD	
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DATE	RESULT	Children CD4 %	DATE	RESULT
day/month/year			day/month/year	
Date:			Date:	
Date:			Date:	
Date:			Date:	

Most recent available tests		Date	Results of Viral Resistance Test - submit together with application to: TLART@HEALTH.GOV.ZA
Hb (g/dL)			
ALT (U/L)			
Creatinine (µmol/L)			
Creatinine Clearance (mL/min/1.73 m ²)			
White cell count (x 10 ⁹ /L)			
Hepatitis B status (HbsAg pos/neg)			

Concomitant medication and indication	
Children: <i>Is child able to swallow a tablet?</i>	
Please ensure that laboratory resistance test is submitted with this form!	
<i>For office use only:</i>	
Date received:	
Recommendation:	
Date:	