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/m^2)		***Height (child)***	

FACILITY DETAILS

Facility Name			
Province			
Doctor In Charge Of Patient/ Authorised Prescriber			
Doctor's Contact Number			
Doctor and Pharmacist Email Addresses			
Signature of Authorised Prescriber		**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				

Reason for discontinuation codes: *SE = Side effect, F= Failure, FC = Formulary change, NC = Non adherent*

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**		
DATE day/month/year		**RESULT**	***Children CD4 %***	**DATE** day/month/year		**RESULT**
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: *Is child able to swallow a tablet?*	

Please ensure that laboratory resistance test is submitted with this form!
For office use only:
Date received:
Recommendation: Date: