HEALTH RISK ASSESSMENT AND HIV SCREENING FORM

Section 1: Personal details

Are you on a Medical Aid Scheme [Y] [N]

Name of Medical Aid Scheme

Membership number

Reality Membership number

Dependent code

ID or passport number

Date of birth [D][D] [M][M] [Y][Y][Y][Y]

First name

Surname

Gender [M] [F] If female, are you pregnant? [Y] [N] If yes, number of weeks

Ethnicity [Black] [White] [Coloured] [Indian/Asian] [Other]

Are you disabled? [Y] [N]

Cell phone number

Telephone (w)

Email address

Business unit (if applicable)

Employment status [ ] Permanent [ ] Contractor [ ] Full time [ ] Part time [ ] Pensioner [ ] Not applicable

Job grade or rank (if applicable)

Province

Cluster (if applicable)

Station (if applicable)

Your doctor's first name

Your doctor's surname

Suburb where your doctor practises

Your doctor's telephone number (with dialling code)

Section 2: Select screening services

	Tick applicable			Tick applicable	
Health Risk Assessment(HRA)	Y	N	TB finger prick test	Y	N
HIV pre-test counselling	Y	N	Prostate Specific Antigen (PSA) screening	Y	N
HIV testing and post-test counselling	Y	N			

Section 3: Participant consent

I hereby declare and confirm that:

3.1. In terms of the Protection of Personal Information Act, 4 of 2013 ("POPI"), I consent to my personal information being collected, used, processed and shared with third parties, so that I can receive health-related benefits, provided that my information is securely stored. I also understand that I have the right to withdraw my consent, update, correct or delete my details at any time.

3.2. I understand the purpose of the services, outlined in Section 2 above is to assess my health status and to identify certain health risks.

3.3. I voluntarily consent to participate in the services outlined in Section 2 above and agree not to hold any health professional responsible for any injury I may suer as a result. I understand that some of the health screening tests require a finger prick and that this may be painful, cause me to feel faint or dizzy and that there may be mild bruising afterwards.

3.4. I understand that further investigations may be necessary, based on my test results, and give permission for my information to be shared, provided it is kept confidential, with my doctor or contracted service provider(s) so that I can receive appropriate follow-up intervention.
3.5. Should I be informed that my HIV test result be positive, I agree to be contacted telephonically by a treatment support counsellor to assist me with registration on an AIDS disease management programme.
3.6. I consent to my de-identified data being used for statistical or research purposes and give permission for this, provided it will be kept confidential by all parties concerned.
3.7. I confirm that I understand the consent that is required and acknowledge that I have been given enough information to make a decision to participate in the services that I have selected on this form:

Participant signature _____ Date D D M M Y Y Y Y Location _____

Section 4: Health Risk Assessment and Screening

4.1. General health

Over the last two weeks, have you been bothered by any of the following problems?

Little interest or pleasure in doing things	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Feeling down, depressed or hopeless	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Felt nervous or on edge	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Not being able to stop or control worrying	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day

4.2. Health status

Has your father, brother or son had coronary heart disease or stroke before age 55?	Y	N
Has your mother, sister or daughter had coronary heart disease or stroke before age 65?	Y	N
Have you been diagnosed with heart disease?	Y	N
Have you been diagnosed with high blood pressure?	Y	N
Do you take medication for high blood pressure?	Y	N
Do you take medication for high cholesterol?	Y	N
Have any of your immediate family members been diagnosed with diabetes? (parent, brother, sister, child)	Y	N
Have any of your other family members been diagnosed with diabetes? (grandparent, aunt, uncle, cousin)	Y	N
Have you been diagnosed with diabetes?	Y	N
Do you take diabetes medication?	Y	N
Do you take any chronic medication?	Y	N
Are you registered on a scheme chronic management programme?	Y	N

4.3. Lifestyle

Do you smoke? ☐ Never smoked ☐ Ex-smoker ☐ Current smoker less than 20 cigarettes/day ☐ Current smoker more than 20 cigarettes/day

Do you perform 30 minutes of physical activity at least 5 days a week? Y N

Do you exercise? ☐ Once a week or less ☐ 2-3 times a week ☐ 3-4 times a week ☐ 5-6 times a week ☐ 6+ times a week

Do you eat fruit, vegetables or berries daily? Y N

How many times have you had (5 for male / 4 for female) or more alcohol-drinks in a day, in the past year? ☐ Never ☐ Once ☐ Twice ☐ 3 times ☐ 4 times ☐ 5 times

Number of alcoholic drinks that you consume per week? ☐☐☐

How well are you overall in your own opinion? ☐ Very well ☐ Quite well ☐ OK ☐ Quite unwell ☐ Very unwell

How motivated are you to improve your lifestyle? ☐ Very interested ☐ Somewhat interested ☐ Not interested

How stressed are you? ☐ Not stressed ☐ A bit stressed ☐ Quite stressed ☐ Very stressed ☐ Highly stressed

What causes you the most stress? ☐ Work ☐ Money ☐ Relationship ☐ Family ☐ Health

Do you have any of these medical conditions (tick "none" if you have none)?

☐ Anxiety	☐ Depression	☐ High Blood Pressure	☐ Arthritis	☐ Diabetes	☐ Irritable Bowel Syndrome
☐ Asthma	☐ Eczema	☐ Sleep Problems	☐ Back Pain	☐ Hayfever	☐ Cholesterol (high)
☐ Headache	☐ Constipation	☐ Heartburn	☐ None		

Please consider the last 7 calendar-days and answer these three questions:

How many hours have you worked (total for last 7 calendar-days) ___ hours

How many hours of work did you miss for health or wellness reasons in the last 7 days? ___ hours

How much did health and wellness concerns impact your ability to work while at work in the last 7 days? (from 0 = no impact, to 10 = high impact / preventing all work)? 1 2 3 4 5 6 7 8 9 10

Please select one of the following personal health and wellness goals

- ☐ Lose 4 kg
- ☐ Lose 8 kg
- ☐ Exercise 3 times a week
- ☐ Walk 8000 steps a day
- ☐ Stop smoking
- ☐ Eat five fruits and veg a day
- ☐ Eat a healthy breakfast every day
- ☐ Sleep 7+ hours a night
- ☐ Relax or meditate for 10 minutes twice a day
- ☐ Watch TV for less than 2 hours a day

4.4. TB screening

Have you had a cough for more than 2 weeks?	Y	N
Have you experienced night sweats for more than 2 weeks?	Y	N
Have you had fevers for more than 2 weeks?	Y	N
Have you had unexplained weight loss of more than 3kg in the last 4 weeks?	Y	N

** If "YES" to one or more of the above questions, refer individual for finger prick test, TB clinic or doctor for further investigation.

4.5. Health measurements

Height (without shoes) cm	cm
Weight (without shoes) Nearest kg	nearest kg
Waist circumference cm	cm
Hip circumference cm	cm
Have you eaten in the last 7 hours?	Y N
Systolic blood pressure (top number) mmHg	mmHg
Diastolic blood pressure (bottom number) mmHg	mmHg
Glucose mmol/L	mmol/L
Total Cholesterol mmol/L	mmol/L

4.6. BP 5-minute follow-up

Systolic blood pressure (top number) 5 min mmHg	mmHg
Diastolic blood pressure (bottom number) 5 min mmHg	mmHg

4.7. HRA healthcare professional's declaration

I confirm that I have provided counselling to the person being tested, according to the guidelines as set out by the medical scheme Y N

Healthcare professional name

Signature

Date D D M M Y Y Y Y

Section 5: HIV counselling and testing

5.1. Participant pretest counselling

I have received pre-test counselling Y N

I did not want pre-test counselling Y N

Participant signature

Date D D M M Y Y Y Y

5.2. HIV health status

Have you been tested for HIV in the past 12 months? Y N

If yes, when D D M M Y Y Y Y Result

If positive, are you receiving treatment? Y N

Are you on a scheme disease managed care programme? Y N

Do you currently have TB? Y N

TB treatment start date D D M M Y Y Y Y

5.3. Test result (to be completed by HIV Health Professional Counsellor)

Name of HIV screening test

Batch Number Expiry Date D D M M Y Y Y Y

Result Negative Positive Inconclusive Not done

Name of confirmatory HIV screening test

Batch Number Expiry Date D D M M Y Y Y Y

Result Negative Positive Inconclusive Not done

5.4. Participant post-test counselling

I have received post-test counselling Y N

Participant signature Date D D M M Y Y Y Y

5.5. HIV healthcare professional's declaration

I confirm that I have provided post-test counselling to the person being tested, according to the guidelines as set out by the medical scheme. Y N

Healthcare professional name and surname

Participant signature Date D D M M Y Y Y Y

Section 6: TB finger prick test

6.1. TB test result (to be completed by Health Professional)

Name of TB Test

Batch Number Expiry Date Expiry Date D D M M Y Y Y Y

Result

6.2 TB healthcare professional's declaration

I confirm that I have provided counselling to the person being tested, according to the guidelines as set out by the medical scheme Y N

Healthcare professional name

Signature Date D D M M Y Y Y Y

Section 7: Prostate Specific Antigen (PSA) screening

7.1. PSA test result (to be completed by Health Professional)

Name of PSA Test

Batch Number Expiry Date Expiry Date D D M M Y Y Y Y

Result

7.2. PSA healthcare professional's declaration

I confirm that I have provided counselling to the person being tested, according to the guidelines as set out by the medical scheme Y N

Healthcare professional name

Signature Date D D M M Y Y Y Y