health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Quotation Advert

Opening Date:	2020-05-29
Closing Date:	2020-06-12
Closing Time:	11:00

INSTITUTION DETAILS

Institution Name:	Umphumulo hospital
Province:	KwaZulu-Natal
Department or Entity:	Department of Health
Division or section:	Central Supply Chain Management
Place where goods / services is required	PHC
Date Submitted	2020-05-29

ITEM CATEGORY AND DETAILS

Quotation Number:	ZNQ: 576-19-20
Item Category:	Goods
Item Description:	SUPPLY PATIENT FOLDER -ADULT FEMALE SPECIFICATION ATTACHED
Quantity (if supplies)	18 738

COMPULSORY BRIEFING SESSION / SITE VISIT

Select Type:	Not Applicable
Date :	
Time:	
Venue:	

QUOTES CAN BE COLLECTED FROM:	R74 GREYTOWN ROAD MAPHUMULO 4470 (PROCUREMENT DEPARTMENT)
QUOTES SHOULD BE DELIVERED TO:	R74 GREYTOWN ROAD MAPHUMULO 4470 (SECURITY MAIN GATE)

ENQUIRIES REGARDING THE ADVERT MAY BE DIRECTED TO:

Name:	SIBONELO SITHOLE
Email:	SIBONELO.SITHOLE@KZNHEALTH.GOV.ZA
Contact Number:	032 481 4181

29/05/2020

No late quotes will be considered

STANDARD QUOTE DOCUMENTATION SUPPLY CHAIN MANAGEMENT OVER R30 000.00

YOU ARE HEREBY INVITED TO QUOTE FOR REQUIREMENTS AT: UMPHUMULO HOSPITAL

DATE ADVERTISED: 2020-05-29 CLOSING DATE: 2020-06-12 CLOSING TIME: 11:00

FACSIMILE NUMBER: 032 481 4166 E-MAIL ADDRESS: SIBONELO.SITHOLE@KZNHEALTH

PHYSICAL ADDRESS: R74 GREYTOWN ROAD MAPHUMULO 4470

ZNQ NUMBER: 576-19-20

DESCRIPTION: SUPPL PATIENT FOLDER ADULT (FEMALE)

CONTRACT PERIOD ONCE OFF *(if applicable)* VALIDITY PERIOD 60 Days SARS PIN

CENTRAL SUPPLIER DATABASE REGISTRATION (CSD) NO.

UNIQUE REGISTRATION REFERENCE

DEPOSITED IN THE QUOTE BOX SITUATED AT *(STREET ADDRESS)*

R74 GREYTOWN ROAD MAPHUMULO 4470 (SECURITY MAIN GATE)

Bidders should ensure that quotes are delivered timeously to the correct address. If the quote is late, it will not be accepted for consideration.

The quote box is open from 08:00 to 15:30.

ALL QUOTES MUST BE SUBMITTED ON THE OFFICIAL FORMS – (NOT TO BE RE-TYPED)

THIS QUOTE IS SUBJECT TO THE PREFERENTIAL PROCUREMENT POLICY FRAMEWORK ACT AND THE PREFERENTIAL PROCUREMENT REGULATIONS, 2011, THE GENERAL CONDITIONS OF CONTRACT (GCC) AND, IF APPLICABLE, ANY OTHER SPECIAL CONDITIONS OF CONTRACT.

THE FOLLOWING PARTICULARS MUST BE FURNISHED
(FAILURE TO DO SO WILL RESULT IN YOUR QUOTE BEING DISQUALIFIED)

NAME OF BIDDER .....

POSTAL ADDRESS .....

STREET ADDRESS .....

TELEPHONE NUMBER CODE.....NUMBER..... FACSIMILE NUMBER CODE .....NUMBER.....

CELLPHONE NUMBER .....

E-MAIL ADDRESS .....

VAT REGISTRATION NUMBER (If VAT vendor) .....

HAS A B-BBEE STATUS LEVEL VERIFICATION CERTIFICATE BEEN SUBMITTED? (SBD 6.1) YES NO

[A B-BBEE STATUS LEVEL VERIFICATION CERTIFICATE/SWORN AFFIDAVIT (FOR EMEs& QSEs) MUST BE SUBMITTED IN ORDER TO QUALIFY FOR PREFERENCE POINTS FOR B-BBEE]

OFFICIAL PRICE PAGE FOR QUOTATIONS ZNQ NUMBER: 576-19-20

DESCRIPTION: SUPPL PATIENT FOLDER ADULT (FEMALE)

SIGNATURE OF BIDDER ..... DATE.....
[By signing this document I hereby agree to all terms and conditions]

CAPACITY UNDER WHICH THIS QUOTE IS SIGNED.....

Item No	Quantity	Description	Brand & model	Country of manufacture	Price R	Price c
	01	SUPPL PATIENT FOLDER ADULT (FEMALE)				
		SPECIFICATION ATTACHED				
		BEE STATUS AND A VALID TAX CLEARANCE MUST BE ATTACHED				
		NB:NO EMAILED QUOTATIONS WILL BE ACCEPTED				
		NB:EACH QUOTATION MUST HAVE ITS OWN SUPPORTING				
		DOCUMENTS				
VALUE ADDED TAX @ 15% (Only if VAT Vendor)						
TOTAL QUOTATION PRICE (VALIDITY PERIOD 60 Days)						

Does This Offer Comply With The Specification?		Does The Article Conform To The S.A.N.S. / S.A.B.S. Specification?	
Is The Price Firm?		State Delivery Period E.G. *E.G. 1day, 1week*	

Enquiries regarding the quote may be directed to:

Contact Person: SIBONELO S..... Tel: 032 481 418

E-Mail Address: SIBONELO.SITHOLE@KZNHEA

Enquiries regarding technical information may be directed to:

Contact Person: B.L MDLETSHE Tel: 032 4814132

DECLARATION OF INTEREST

1. Any legal person, including persons employed by the state[1], or persons having a kinship with persons employed by the state, including a blood relationship, may make an offer or offers in terms of this invitation to quote (includes a price quotation, advertised competitive quote, limited quote or proposal). In view of possible allegations of favouritism, should the resulting quote, or part thereof, be awarded to persons employed by the state, or to persons connected with or related to them, it is required that the bidder or his/her authorised representative declare his/her position in relation to the evaluating/adjudicating authority where-
   - the bidder is employed by the state; and/or
   - the legal person on whose behalf the bidding document is signed, has a relationship with persons/a person who are/is involved in the evaluation and or adjudication of the quote(s), or where it is known that such a relationship exists between the person or persons for or on whose behalf the declarant acts and persons who are involved with the evaluation and or adjudication of the quote.
2. In order to give effect to the above, the following questionnaire must be completed and submitted with the quote.

2.1. Full Name of bidder/representative.....
2.2. Identity Number: .....
2.3. Position occupied in the Company (director, trustee, shareholder[2]):.....
2.4. Company Registration Number: .....
2.5. Tax Reference Number: .....
2.6. VAT Registration Number: .....

2.7. The names of all directors / trustees / shareholders / members, their individual identity numbers, tax reference numbers and, if applicable, employee / persal numbers must be indicated in paragraph 3 below. [TICK APPLICABLE]

2.8. Are you or any person connected with the bidder presently employed by the state? YES ☐ NO ☐

2.8.1. If so, furnish the following particulars:
Name of person / director / trustee / shareholder/ member: .....
Name of state institution at which you or the person connected to the bidder is employed:.....
Position occupied in the state institution: .....Any other particulars:.....

2.8.2. If you are presently employed by the state, did you obtain the appropriate authority to undertake remunerative work outside employment in the public sector? YES ☐ NO ☐

2.8.2.1. If yes, did you attach proof of such authority to the quote document?

(Note: Failure to submit proof of such authority, where applicable, may result in the disqualification of the quote.)

2.8.2.2. If no, furnish reasons for non-submission of such proof: .....

2.9. Did you or your spouse, or any of the company's directors / trustees / shareholders / members or their spouses conduct business with the state in the previous twelve months? YES ☐ NO ☐

2.9.1. If so, furnish particulars:.....

2.10. Do you, or any person connected with the bidder, have any relationship (family, friend, other) with a person employed by the state and who may be involved with the evaluation and or adjudication of this quote? YES ☐ NO ☐

2.10.1. If so, furnish particulars:.....

2.11. Are you, or any person connected with the bidder, aware of any relationship (family, friend, other) between any other bidder and any person employed by the state who may be involved with the evaluation and or adjudication of this quote? YES ☐ NO ☐

2.11.1. If so, furnish particulars:.....

2.12. Do you or any of the directors / trustees / shareholders / members of the company have any interest in any other related companies whether or not they are bidding for this contract? YES ☐ NO ☐

2.12.1. If so, furnish particulars:.....

3. **Full details of directors / trustees / members / shareholders.**

NB: The Department Of Health will validate **details of directors / trustees / members / shareholders** on CSD. It is the suppliers' responsibility to ensure that their details are up-to-date and verified on CSD. If the Department cannot validate the **information** on CSD, the quote will not be considered and passed over as non-compliant according to National Treasury Instruction Note 4 (a) 2016/17.

4 DECLARATION

I, THE UNDERSIGNED (NAME).....CERTIFY THAT THE INFORMATION FURNISHED IN PARAGRAPHS 2.

I ACCEPT THAT THE STATE MAY REJECT THE QUOTE OR ACT AGAINST ME SHOULD THIS DECLARATION PROVE TO BE FALSE.

.....	.....	.....	.....
Name of bidder	Signature	Position	Date

[1]"State" means –
a) any national or provincial department, national or provincial public entity or constitutional institution within the meaning of the Public Finance Management
c) provincial legislature;
d) national Assembly or the national Council of provinces; or

SPECIAL CONTRACT CONDITIONS OF QUOTATIONS

1. AMENDMENT OF CONTRACT

1.1. Any amendment to or renunciation of the provisions of the contract shall at all times be done in writing and shall be signed by both parties.

2. CHANGE OF ADDRESS

2.1. Bidders must advise the Department of Health (institution where the offer was submitted) should their address (*domicilium citandi et executandi*) details change from the time of bidding to the expiry of the contract.

3. GENERAL CONDITIONS ATTACHED TO THIS QUOTATION

3.1. The institution is under no obligation to accept the lowest or any quote.
3.2. The price quoted must include VAT (if VAT vendor). However, it must be noted that the department reserves the right to evaluate all quotations excluding VAT as some bidders may not be VAT vendors.
3.3. The bidder must ensure the correctness & validity of quote:
(i) *that the price(s), rate(s) & preference quoted cover all for the work/item (s) & accept that any mistakes regarding the price (s) & calculations will be at the bidder's risk*
3.4. The bidder must accept full responsibility for the proper execution & fulfilment of all obligations conditions devolving on under this agreement, as the Principal (s) liable for the due fulfilment of this contract.
3.5. This quotation will be evaluated based on the 80/20 points system, specification & correctness of information. All required documentation must be completed in full and submitted.
3.6. Offers must comply strictly with the specification.
3.7. Only offers that meet or are greater than the specification will be considered.
3.8. Late quotes will not be considered.
3.9. Expired product/s will not be accepted. All products supplied must be valid for a minimum period of six months.
3.10. A bidder not registered on the Central Suppliers Database or verification has failed will not be considered.
3.11. All delivery costs must be included in the quote price, for delivery at the prescribed destination.
3.12. Only firm prices will be accepted. Such prices must remain firm for the contract period. Non-firm prices (including rates of exchange variations) will not be considered.
3.13. In cases where different delivery points influence the pricing, a separate pricing schedule must be submitted for each delivery point.
3.14. In the event of a bidder having multiple quotes, only the cheapest according to specification will be considered. Furthermore a verification will be done to identify if bidders have multiple companies and are quoting (cover-quoting) for this bid. In such instances only the cheapest bid according to specification will be considered.

4. SPECIAL INSTRUCTIONS AND NOTICES TO BIDDERS REGARDING THE COMPLETION OF THIS QUOTATION.

4.1. Unless inconsistent with or expressly indicated otherwise by the context, the singular shall include the plural and vice versa and with words importing the masculine gender shall include the feminine and the neuter.
4.2. Under no circumstances whatsoever may the quotation/bid forms be retyped or redrafted. Photocopies of the original bid documentation may be used, but an original signature must appear on such photocopies.
4.3. The bidder is advised to check the number of pages and to satisfy himself that none are missing or duplicated.
4.4. Quotation submitted must be complete in all respects.
4.5. Any alteration made by the bidder must be initialled.
4.6. Use of correcting fluid is prohibited
4.7. Quotation will be opened in public as soon as practicable after the closing time of quotation.
4.8. Where practical, prices are made public at the time of opening quotations.
4.9. If it is desired to make more than one offer against any individual item, such offers should be given on a photocopy of the page in question. Clear indication thereof must be stated on the schedules attached.

5. SPECIAL INSTRUCTIONS REGARDING HAND DELIVERED QUOTATIONS

5.1. Quotation shall be lodged at the address indicated not later than the closing time specified for their receipt, and in accordance with the directives in the quotation documents.
5.2. Each quotation shall be addressed in accordance with the directives in the quotation documents and shall be lodged in a separate sealed envelope, with the name and address of the bidder, the quotation number and closing date indicated on the envelope. The envelope shall not contain documents relating to any quotation other than that shown on the envelope. If this provision is not complied with, such quotations/bids may be rejected as being invalid.
5.3. All quotations received in sealed envelopes with the relevant quotation numbers on the envelopes are kept unopened in safe custody

date and time of quotation will be considered.

5.5. No quotation/bid sent through the post will be considered if it is received after the closing date and time stipulated in the quotation documentation, and proof of posting will not be accepted as proof of delivery.
5.6. Quotation documents must not be included in packages containing samples. Such quotations may be rejected as being invalid.

6. SAMPLES

6.1. In the case of the quote document stipulating that samples are required, the supplier will be informed in due course when samples should be provided to the institution. (This decreases the time of safety and storage risk that may be incurred by the respective institution). The bidders sample will be retained if such bidder wins the contract.
(i) If a company/s who has not won the quote requires their samples, they must advise the institution in writing of such.
(ii) If samples are not collected within three months of close of quote the institution reserves the right to dispose of them at their discretion.

6.2. **Samples must be made available when requested in writing or if stipulated on the document.**
(i) If a Bidder fails to provide a sample of their product on offer for scrutiny against the set specification when requested, their offer will be rejected. All testing will be for the account of the bidder.

7. COMPULSORY SITE INSPECTION / BRIEFING SESSION

7.1. Bidders who fail to attend the compulsory meeting will be disqualified from the evaluation process.

(i) The institution has determined that a compulsory site meeting WILL NOT take place
(ii) Date ____/____/____ Time____:____ Place _____

Institution Stamp:	Institution Site Inspection / briefing session Official Full Name: ..... Signature: ..... Date: .....

8. STATEMENT OF SUPPLIES AND SERVICES

8.1. The contractor shall, when requested to do so, furnish particulars of supplies delivered or services executed. If he/she fails to do so, the Department may, without prejudice to any other rights which it may have, institute inquiries at the expense of the contractor to obtain the required particulars.

9. SUBMISSION AND COMPLETION OF SBD 6.1

9.1. Should a bidder wish to qualify for preference points they must complete a SBD 6.1 document. Failure by a bidder to provide all relevant information required, will result in such a bidder not being considered for preference point's allocation. The preferences applicable on the closing date will be utilized. Any changes after the closing date will not be considered for that particular quote.

10. TAX COMPLIANCE REQUIREMENTS

10.1. In the event that the tax compliance status has failed on CSD, ***it is the suppliers' responsibility to provide a SARS pin in order for the institution to validate the tax compliance status of the supplier.***
10.2. In the event that the institution cannot validate the suppliers' tax clearance on SARS as well as the Central Suppliers Database, ***the quote will not be considered and passed over as non-compliant according to National Treasury Instruction Note 4 (a) 2016/17.***

11. TAX INVOICE

11.1. A tax invoice shall be in the currency of the Republic of South Africa and shall contain the following particulars:

(i) the name, address and registration number of the supplier;
(ii) the name and address of the recipient;
(iii) an individual serialized number and the date upon which the tax invoice is issued;
(iv) a description and quantity or volume of the goods or services supplied;
(v) the official department order number issued to the supplier;
(vi) the value of the supply, the amount of tax charged;
(vii) the words tax invoice in a prominent place.

12. PATENT RIGHTS

13. PENALTIES

13.1. If at any time during the contract period, the service provider is unable to perform in a timely manner, the service provider must notify the institution in writing/email of the cause of and the duration of the delay. Upon receipt of the notification, the institution should evaluate the circumstances and, if deemed necessary, the institution may extend the service provider's time for performance.

13.2. In the event of delayed performance that extends beyond the delivery period, the institution is entitled to purchase commodities of a similar quantity and quality as a substitution for the outstanding commodities, without terminating the contract, as well as return commodities delivered at a later stage at the service provider's expense.

13.3. Alternatively, the institution may elect to terminate the contract and procure the necessary commodities in order to complete the contract. In the event that the contract is terminated the institution may claim damages from the service provider in the form of a penalty. The service provider's performance should be captured on the service provider database in order to determine whether or not the service provider should be awarded any contracts in the future.

13.4. If the supplier fails to deliver any or all of the goods or to perform the services within the period(s) specified in the contract, the purchaser shall, without prejudice to its other remedies under the contract, deduct from the contract price, as a penalty, a sum calculated on the delivered price of the delayed goods or unperformed services using the current prime interest rate calculated for each day of the delay until actual delivery or performance.

14. TERMINATION FOR DEFAULT

14.1. The purchaser, without prejudice to any other remedy for breach of contract, by written notice of default sent to the supplier, may terminate this contract in whole or in part:

(i) if the supplier fails to deliver any or all of the goods within the period(s) specified in the contract,

(ii) if the supplier fails to perform any other obligation(s) under the contract; or

(iii) if the supplier, in the judgment of the purchaser, has engaged in corrupt or fraudulent practices in competing for or in executing the contract.

14.2. In the event the purchaser terminates the contract in whole or in part, the purchaser may procure, upon such terms and in such manner as it deems appropriate, goods, works or services similar to those undelivered, and the supplier shall be liable to the purchaser for any excess costs for such similar goods, works or services.

14.3. Where the purchaser terminates the contract in whole or in part, the purchaser may decide to impose a restriction penalty on the supplier by prohibiting such supplier from doing business with the public sector for a period not exceeding 10 years.

15. FAILURE TO COMPLY WITH ABOVE WILL RESULT IN YOUR QUOTE BEING PASSED OVER.

PREFERENCE POINTS CLAIM FORM IN TERMS OF THE PREFERENTIAL PROCUREMENT REGULATIONS 2017

This preference form must form part of all quotes invited. It contains general information and serves as a claim form for preference points for Broad-Based Black Economic Empowerment (B-BBEE) Status Level of Contribution

NB: BEFORE COMPLETING THIS FORM, BIDDERS MUST STUDY THE GENERAL CONDITIONS, DEFINITIONS AND DIRECTIVES APPLICABLE IN RESPECT OF B-BBEE, AS PRESCRIBED IN THE PREFERENTIAL PROCUREMENT REGULATIONS, 2017.

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1. GENERAL CONDITIONS

1.1 The following preference point systems are applicable to all quotes:

- the 80/20 system for requirements with a Rand value of up to R50 000 000 (all applicable taxes included); and

1.2 The value of this quote is estimated to not exceed R50 000 000 (all applicable taxes included) and therefore the 80/20 preference point system shall be applicable.

1.3 Points for this quote shall be awarded for:
(a) Price; and
(b) B-BBEE Status Level of Contributor.

1.4 The maximum points for this quote is allocated as follows:

	POINTS
PRICE	80
B-BBEE STATUS LEVEL OF CONTRIBUTOR	20
Total points for Price and B-BBEE must not exceed	100

1.5 Failure on the part of a bidder to submit proof of B-BBEE Status level of contributor together with the quote, will be interpreted to mean that preference points for B-BBEE status level of contribution are not claimed.

1.6 The purchaser reserves the right to require of a bidder, either before a quote is adjudicated or at any time subsequently, to substantiate any claim in regard to preferences, in any manner required by the purchaser.

2. DEFINITIONS

(a) **"B-BBEE"** means broad-based black economic empowerment as defined in section 1 of the Broad-Based Black Economic Empowerment Act;

(b) **"B-BBEE status level of contributor"** means the B-BBEE status of an entity in terms of a code of good practice on black economic empowerment, issued in terms of section 9(1) of the Broad-Based Black Economic Empowerment Act;

(c) **"bid"** means a written offer in a prescribed or stipulated form in response to an invitation by an organ of state for the provision of goods or services, through price quotations, advertised competitive bidding processes or proposals;

(d) **"Broad-Based Black Economic Empowerment Act"** means the Broad-Based Black Economic Empowerment Act, 2003 (Act No. 53 of 2003);

(e) **"EME"** means an Exempted Micro Enterprise in terms of a code of good practice on black economic empowerment issued in terms of section 9 (1) of the Broad-Based Black Economic Empowerment Act;

(f) **"functionality"** means the ability of a tenderer to provide goods or services in accordance with specifications as set out in the tender documents.

(g) **"prices"** includes all applicable taxes less all unconditional discounts;

(h) **"proof of B-BBEE status level of contributor"** means:

1) B-BBEE Status level certificate issued by an authorized body or person;

2) A sworn affidavit as prescribed by the B-BBEE Codes of Good Practice;

3) Any other requirement prescribed in terms of the B-BBEE Act;

(i) **"QSE"** means a qualifying small business enterprise in terms of a code of good practice on black economic empowerment issued in

3. POINTS AWARDED FOR PRICE

3.1 THE 80/20 PREFERENCE POINT SYSTEMS

A maximum of 80 points is allocated for price on the following basis:

$$Ps = 80\left(1 - \frac{Pt - P\min}{P\min}\right)$$ Where

Ps = Points scored for price of bid under consideration
Pt = Price of bid under consideration
Pmin = Price of lowest acceptable bid

4. POINTS AWARDED FOR B-BBEE STATUS LEVEL OF CONTRIBUTOR

4.1 In terms of Regulation 6 (2) and 7 (2) of the Preferential Procurement Regulations, preference points must be awarded to a bidder for attaining the B-BBEE status level of contribution in accordance with the table below:

B-BBEE Status Level of Contributor	Number of points (80/20 system)
1	20
2	18
3	14
4	12
5	8
6	6
7	4
8	2
Non-compliant contributor	0

5. BID DECLARATION

5.1 Bidders who claim points in respect of B-BBEE Status Level of Contribution must complete the following:

6. B-BBEE STATUS LEVEL OF CONTRIBUTOR CLAIMED IN TERMS OF PARAGRAPHS 1.4 AND 4.1

6.1 B-BBEE Status Level of Contributor: = ...(maximum of 20 points)

(Points claimed in respect of paragraph 7.1 must be in accordance with the table reflected in paragraph 4.1 and must be substantiated by relevant proof of B-BBEE status level of contributor.

7. SUB-CONTRACTING

(Tick applicable box)

7.1 Will any portion of the contract be sub-contracted? YES ☐ NO ☐

7.1.1 If yes, indicate:

i) What percentage of the contract will be subcontracted.....%
ii) The name of the sub-contractor.....
iii) The B-BBEE status level of the sub-contractor.....

8. Whether the sub-contractor is an EME or QSE (Tick applicable box)

iv) Specify, by ticking the appropriate box, if subcontracting with an enterprise in terms of Preferential Procurement Regulations,2017: YES ☐ NO ☐

Designated Group: An EME or QSE which is at last 51% owned by:	EME √	QSE √
Black people		
Black people who are youth		
Black people who are women		
Black people with disabilities		
Black people living in rural or underdeveloped areas or townships		
Cooperative owned by black people		
Any QSE		

9. **DECLARATION WITH REGARD TO COMPANY/FIRM**

9.1 Name of company/firm:.....

9.2 VAT registration number:.....

9.3 Company registration number:.....

9.4 TYPE OF COMPANY/ FIRM [TICK APPLICABLE BOX]

- ☐ Partnership/Joint Venture / Consortium
- ☐ One person business/sole propriety
- ☐ Close corporation
- ☐ Company
- ☐ (Pty) Limited

9.5 DESCRIBE PRINCIPAL BUSINESS ACTIVITIES

.....

.....

9.6 COMPANY CLASSIFICATION [TICK APPLICABLE BOX]

- ☐ Manufacturer
- ☐ Supplier
- ☐ Professional service provider
- ☐ Other service providers, e.g. transporter, etc.

9.7 Total number of years the company/firm has been in business:.....

9.8 I/we, the undersigned, who is / are duly authorised to do so on behalf of the company/firm, certify that the points claimed, based on the B-BBE status level of contributor indicated in paragraphs 1.4 and 6.1 of the foregoing certificate, qualifies the company/ firm for the preference(s) shown and I / we acknowledge that:

i) The information furnished is true and correct;

ii) The preference points claimed are in accordance with the General Conditions as indicated in paragraph 1 of this form;

iii) In the event of a contract being awarded as a result of points claimed as shown in paragraphs 1.4 and 6.1, the contractor may be required to furnish documentary proof to the satisfaction of the purchaser that the claims are correct;

iv) If the B-BBEE status level of contributor has been claimed or obtained on a fraudulent basis or any of the conditions of contract have not been fulfilled, the purchaser may, in addition to any other remedy it may have –

(a) disqualify the person from the bidding process;

(b) recover costs, losses or damages it has incurred or suffered as a result of that person's conduct;

(c) cancel the contract and claim any damages which it has suffered as a result of having to make less favourable arrangements due to such cancellation;

(d) recommend that the bidder or contractor, its shareholders and directors, or only the shareholders and directors who acted on a fraudulent basis, be restricted by the National Treasury from obtaining business from any organ of state for a period not exceeding 10 years, after the *audi alteram partem* (hear the other side) rule has been applied; and

(e) forward the matter for criminal prosecution.

WITNESSES 1. ..... 2.	..... SIGNATURE(S) OF BIDDERS(S) DATE: ..... ADDRESS..... ....

Table of Contents

HPRS Label

DEMOGRAPHIC DETAILS

Allergy sticker

Patient file number	___ – ___ – ____
ID/Passport number	
Name	
Surname	
Date of birth	d d m m y y y y
Religion	
Language	
Marital status	Single / Married / Divorced / Widowed / Cohabitation

RESIDENTIAL ADDRESS

House number and street name	
Suburb	
Town/City	
Postal code	
Home telephone number	
Cell number	

WORK CONTACT DETAILS (If employed)

Name of employer	
Work address	
Work telephone number	

ALTERNATIVE CONTACT DETAILS

Next of kin (name & surname)	
Relationship to patient	
Home telephone number	
Cell number	

Date completed	d d m m y y y y

SUBSEQUENT CHANGES TO DEMOGRAPHIC DETAILS

At subsequent visits, please ask the patient if any details have changed and reflect only changes

MARITAL STATUS *(Please Tick)*:				
Single				
Married				
Divorced				
Widowed				
Cohabitation				
Date completed				

PHYSICAL ADDRESS				
House number and street name				
Suburb				
Town/city				
Postal code				
Home telephone				
Cell number				
Date completed				

WORK CONTACT DETAILS				
Name of employer				
Work address				
Work telephone number				
Date completed				

ALTERNATIVE CONTACT DETAILS				
Next of kin (name and surname)				
Relationship to patient				
Home telephone number				
Cell number				
Date completed				

PATIENT PROFILE - FIRST VISIT

To be completed at first visit

Social History *(Please Tick)*

Type of employment	Unemployed	Self-employed	Formally employed	
Living conditions	Informal dwelling	Formal house	Hostel	Other institutions (specify)
	Owner	Tenant	Number in household	
	Piped water inside dwelling	Piped water outside dwelling	Communal tap	
	Borehole	Rain water	Rain/stream water	
	Flushing toilet in house	Flushing toilet outside house	Pit toilet	
	VIP toilet	Bucket system	None	
Cooking method	Electricity	Gas	Paraffin	Coal / Firewood
Social assistance	Disability grant	Child support grant	Foster care grant	Pension

Lifestyle Risk Factors *(Please Tick)*

Alcohol	Y	N	(If Yes)	Type	Quantity	Frequency
Smoking/tobacco	Y	N	(If Yes)	Year started	Frequency	
Other substances	Y	N	Specify			

Physical activity	Walk				Run				Active sport			
Healthy eating	Do you have enough food in your home?	Y	N	Do you eat a heaped plate of food?	Y	N	Do you eat food high in Salt?	Y	N	Do you eat food high in Sugar?	Y	N
							Do you eat food high in Fat?	Y	N			

Sexual behavior	Number of current partners		
	Have you had multiple partners in the past six months?	Y	N
	Do you protect yourself and your partner every time you have sex?	Y	N

Family History *(Please Tick)*

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Diabetes
- ☐ TB
- ☐ Mental Health
- ☐ Cancer; if yes, specify _____
- ☐ Other; specify _____

Known Chronic Health Conditions

			Year diagnosed				Current medication/treatment
HIV	Y	N	Y	Y	Y	Y	
TB	Y	N	Y	Y	Y	Y	
Hypertension	Y	N	Y	Y	Y	Y	
Ischaemic heart disease	Y	N	Y	Y	Y	Y	
Diabetes	Y	N	Y	Y	Y	Y	
Asthma/ COPD	Y	N	Y	Y	Y	Y	
Mental health	Y	N	Y	Y	Y	Y	
Epilepsy	Y	N	Y	Y	Y	Y	
Rheumatic heart disease	Y	N	Y	Y	Y	Y	
Physical disability; e.g. blindness, limited mobility, etc.	Y	N	Y	Y	Y	Y	
Chemotherapy	Y	N	Y	Y	Y	Y	
Liver disease	Y	N	Y	Y	Y	Y	
Kidney disease	Y	N	Y	Y	Y	Y	
Other; specify	Y	N	Y	Y	Y	Y	
Date completed							

PATIENT PROFILE - FIRST VISIT

To be completed at first visit

Past Surgical History

Previous operations	Date	Complications

Allergies	Y	N	Specify

Sexual Reproductive Health History

Obstetric History

Year	Gestation age	Delivery mode *NV=Normal Vaginal* *FS=Forceps* *VE=Vacuum Extraction* *CS=Caesarean Section*	Baby's weight	Pregnancy outcome *A=Alive* *ID= Infant death* *NND=Neonatal death* *IUD=Intra-uterine Death*

Contraceptive History

Current contraceptive method														
Start date of current contraception														
Pap smear			When was the last Pap smear done?									Result		
Date completed														

PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Social History *(Please Tick)*

Type of employment	Unemployed	Self-employed	Formally employed		
Living conditions	Informal dwelling	Formal house	Hostel	Other institutions (specify)	
	Owner	Tenant	Number in household		
	Piped water inside dwelling	Piped water outside dwelling	Communal tap		
	Borehole	Rain water	Rain/stream water		
	Flushing toilet in house	Flushing toilet outside house	Pit toilet		
	VIP toilet	Bucket system	None		
Cooking method	Electricity	Gas	Paraffin	Coal	Firewood
Social assistance	Disability grant	Child support grant	Foster care grant	Pension	
Date completed					

Social History *(Please Tick)*

Type of employment	Unemployed	Self-employed	Formally employed		
Living conditions	Informal dwelling	Formal house	Hostel	Other institutions (specify)	
	Owner	Tenant	Number in household		
	Piped water inside dwelling	Piped water outside dwelling	Communal tap		
	Borehole	Rain water	Rain/stream water		
	Flushing toilet in house	Flushing toilet outside house	Pit toilet		
	VIP toilet	Bucket system	None		
Cooking method	Electricity	Gas	Paraffin	Coal	Firewood
Social assistance	Disability grant	Child support grant	Foster care grant	Pension	
Date completed					

Social History *(Please Tick)*

Type of employment	Unemployed	Self-employed	Formally employed		
Living conditions	Informal dwelling	Formal house	Hostel	Other institutions (specify)	
	Owner	Tenant	Number in household		
	Piped water inside dwelling	Piped water outside dwelling	Communal tap		
	Borehole	Rain water	Rain/stream water		
	Flushing toilet in house	Flushing toilet outside house	Pit toilet		
	VIP toilet	Bucket system	None		
Cooking method	Electricity	Gas	Paraffin	Coal	Firewood
Social assistance	Disability grant	Child support grant	Foster care grant	Pension	
Date completed					

PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Lifestyle Risk Factors *(Please Tick)*

Alcohol	Y	N	(If Yes)	Type	Quantity	Frequency	
Smoking/tobacco	Y	N	(If Yes)	Year started	Frequency		
Other substances	Y	N	Specify				
Physical activity	Walk		Run		Active sport		
Healthy eating	Do you have enough food in your home?	Y / N	Do you eat a heaped plate of food?	Y / N	Do you eat food high in Salt? Y / N	Do you eat food high in Sugar?	Y / N
					Do you eat food high in Fat? Y / N		
Sexual behavior	Number of current partners						
	Have you had multiple partners in the past six months?	Y / N					
	Do you protect yourself and your partner every time you have sex?	Y / N					
Date completed							

Lifestyle Risk Factors *(Please Tick)*

Alcohol	Y	N	(If Yes)	Type	Quantity	Frequency	
Smoking/tobacco	Y	N	(If Yes)	Year started	Frequency		
Other substances	Y	N	Specify				
Physical activity	Walk		Run		Active sport		
Healthy eating	Do you have enough food in your home?	Y / N	Do you eat a heaped plate of food?	Y / N	Do you eat food high in Salt? Y / N	Do you eat food high in Sugar?	Y / N
					Do you eat food high in Fat? Y / N		
Sexual behavior	Number of current partners						
	Have you had multiple partners in the past six months?	Y / N					
	Do you protect yourself and your partner every time you have sex?	Y / N					
Date completed							

Lifestyle Risk Factors *(Please Tick)*

Alcohol	Y	N	(If Yes)	Type	Quantity	Frequency	
Smoking/tobacco	Y	N	(If Yes)	Year started	Frequency		
Other substances	Y	N	Specify				
Physical activity	Walk		Run		Active sport		
Healthy eating	Do you have enough food in your home?	Y / N	Do you eat a heaped plate of food?	Y / N	Do you eat food high in Salt? Y / N	Do you eat food high in Sugar?	Y / N
					Do you eat food high in Fat? Y / N		
Sexual behavior	Number of current partners						
	Have you had multiple partners in the past six months?	Y / N					
	Do you protect yourself and your partner every time you have sex?	Y / N					
Date completed							

PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History	
Chronic health conditions	
Surgical operations date and complications	
Allergies (specify)	
Sexual reproductive health history	
Date completed	

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History	
Chronic health conditions	
Surgical operations date and complications	
Allergies (specify)	
Sexual reproductive health history	
Date completed	

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History	
Chronic health conditions	
Surgical operations date and complications	
Allergies (specify)	
Sexual reproductive health history	
Date completed	

PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History									
Chronic health conditions									
Surgical operations date and complications									
Allergies (specify)									
Sexual reproductive health history									
Date completed									

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History									
Chronic health conditions									
Surgical operations date and complications									
Allergies (specify)									
Sexual reproductive health history									
Date completed									

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History									
Chronic health conditions									
Surgical operations date and complications									
Allergies (specify)									
Sexual reproductive health history									
Date completed									

PATIENT PROFILE - ANNUAL REVIEW

Update as relevant

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History	
Chronic health conditions	
Surgical operations date and complications	
Allergies (specify)	
Sexual reproductive health history	
Date completed	d d m m y y y y

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History	
Chronic health conditions	
Surgical operations date and complications	
Allergies (specify)	
Sexual reproductive health history	
Date completed	d d m m y y y y

Chronic Health Conditions/Surgical History/Allergies/ Sexual Reproductive Health History	
Chronic health conditions	
Surgical operations date and complications	
Allergies (specify)	
Sexual reproductive health history	
Date completed	d d m m y y y y

ART INITIATION

To be completed at ART initiation or transfer-in

Transfer-in Y | N

Referral clinic _____ **ART start date** d | d | m | m | y | y | y | y

CLINICAL ASSESSMENT: FIRST VISIT AT THIS CLINIC

WHO CLINICAL STAGING

WHO stage	Clinical features			WHO stage	Clinical features		
WHO stage 1	Persistent generalised lymphadenopathy	Y	N	WHO stage 4	Herpes simplex virus lesions >1 month	Y	N
	Other	Y	N		Oesophageal candidiasis	Y	N
WHO stage 2	Weight loss <10% body weight	Y	N		Pneumcystis Pneumonia	Y	N
	Minor mucocutaneous conditions	Y	N		Kaposi sarcoma	Y	N
	Recurrent URTI	Y	N		HIV wasting syndrome	Y	N
	Uncomplicated Herpes Zoste	Y	N		HIV encephalopathy	Y	N
	Other	Y	N		Recurrent pneumonia	Y	N
WHO stage 3	Weight loss >10% body weight	Y	N		Cytomegalovirus	Y	N
	Diarrhoea > 1 month	Y	N		Isosporiasis/ Cryptosporidiosis	Y	N
	Oral candidiasis	Y	N		Bedridden >50%/day most of last month	Y	N
	Severe bacterial infections including Pneumonia	Y	N		Cryptococcal meningitis	Y	N
	Oral hairy leukoplakia	Y	N		Cervical cancer	Y	N
	Prolonged fever	Y	N		Lymphoma	Y	N
	Bedridden <50%/day most of last month	Y	N		Extra-pulmonary TB	Y	N
	Pulmonary TB (current or in last year)	Y	N		Other	Y	N
	Other	Y	N		CD4 result	Y	N

NUTRITIONAL ASSESSMENT

Symptoms present *(Please tick)*	Nausea	Vomitting	Diarrhoea	Severe loss of weight	Difficulty in swallowing
Baseline BMI					

ART INITIATION

To be completed at ART initiation or transfer-in

HISTORY AND EXAMINATION & MANAGEMENT PLAN

Screened for IPT	Y N	Qualifies for IPT	Y N	Started IPT Date d d m m y y y y	Y N
Screened for Cotrimoxazole	Y N	Already on Cotrimoxazole	Y N	Qualifies/started Cotrimoxazole Date d d m m y y y y	Y N
Screened for other/ Fluconazole	Y N	Qualifies/started other/Fluconazole	Y N	Qualifies/started other/Fluconazole Date d d m m y y y y	Y N

CD4 >350 AND stage 1 – 3	Y N		**CD4 <- 350**	Y N	

PSYCHO-SOCIAL READINESS

Has patient attended all required counselling sessions?	Y N	Does patient have a treatment buddy?	Y N
Has patient disclosed to anyone?	Y N	Does patient attend the clinic regularly?	Y N

PRE-ART COUNSELLING

Session	Date	Counsellor/group	Treatment buddy attended?		Comments
General HIV Education and Healthy Living			Y	N	
Antiretroviral Therapy			Y	N	
Adherence Planning			Y	N	
Other			Y	N	

Name and details for treatment buddy

Patient agreed to home visit? Y N	Name of community health worker	Attends a support group Y N

What is clients understanding (in their own words) for wanting ART

BASELINE SAFETY BLOODS

Test	Date	Result	Notes
ALT			
Haemoglobin			
CD4			
Creatinine clearence			
Other:			

CLINICAL FACTORS INFLUENCING REGIMEN CHOICE

On TB treatment	Y N	Has been more than 1 month on ART (excluding PMTCT or PEP)	Y N	**PLAN**
Has severe peripheral neuropathy	Y N	BMI > 27.5	Y N	ARV 1
Has a history of psychiatric illness	Y N	Other		ARV 2
				ARV 3

Next visit in	**weeks**
Health Care Practitioner	
Name	
Surname	
Signature	
SANC/HPCSA No	
Date completed	d d m m y y y y

CLINICAL MANAGEMENT

Visit number	1								2								3							
Date of visit	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y
Vital signs																								
Weight																								
Height																								
BMI																								
Temperature																								
Pulse																								
Blood pressure																								
Blood glucos																								
Urine																								
Basic screening																								
HIV							Y	N							Y	N							Y	N
TB							Y	N							Y	N							Y	N
STI							Y	N							Y	N							Y	N
Diabetes							Y	N							Y	N							Y	N
Lifestyle risk assessment																								
Alcohol							Y	N							Y	N							Y	N
Smoke/tobacco							Y	N							Y	N							Y	N
Physical activity							Y	N							Y	N							Y	N
Healthy eating							Y	N							Y	N							Y	N
Sexual behaviour							Y	N							Y	N							Y	N
Mental health							Y	N							Y	N							Y	N
Known conditions *(Please tick)*	**Heart disease**				**Hypertension**				**Diabetes**				**Asthma/COPD**											
	Other								Specify															
HIV							Y	N							Y	N							Y	N
WHO stage																								
Viral load																								
CD4																								
On ART							Y	N							Y	N							Y	N
TB	**Intensive phase**				**Continuation phase**				**Intensive phase**				**Continuation phase**				**Intensive phase**				**Continuation phase**			
Adherence to medication and pill count							Y	N							Y	N							Y	N
Side effects to medication																								
Other hospital/doctor visits																								
Presenting complaints (Symptoms, duration, severity)																								

CLINICAL MANAGEMENT

Visit number	1	2	3
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

CLINICAL MANAGEMENT

Visit number	4	5	6
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Vital signs			
Weight			
Height			
BMI			
Temperature			
Pulse			
Blood pressure			
Blood glucos			
Urine			
Basic screening			
HIV	Y N	Y N	Y N
TB	Y N	Y N	Y N
STI	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N
Lifestyle risk assessment			
Alcohol	Y N	Y N	Y N
Smoke/tobacco	Y N	Y N	Y N
Physical activity	Y N	Y N	Y N
Healthy eating	Y N	Y N	Y N
Sexual behaviour	Y N	Y N	Y N
Mental health	Y N	Y N	Y N
Known conditions *(Please tick)*	**Heart disease** **Hypertension** **Diabetes** **Asthma/COPD**		
	Other	Specify	
HIV	Y N	Y N	Y N
WHO stage			
Viral load			
CD4			
On ART	Y N	Y N	Y N
TB	Intensive phase | Continuation phase	Intensive phase | Continuation phase	Intensive phase | Continuation phase
Adherence to medication and pill count	Y N	Y N	Y N
Side effects to medication			
Other hospital/doctor visits			
Presenting complaints (Symptoms, duration, severity)			

CLINICAL MANAGEMENT

Visit number	4	5	6
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

CLINICAL MANAGEMENT

Visit number	7		8		9	
Date of visit	d d m m y y y y		d d m m y y y y		d d m m y y y y	
Vital signs						
Weight						
Height						
BMI						
Temperature						
Pulse						
Blood pressure						
Blood glucos						
Urine						
Basic screening						
HIV		Y N		Y N		Y N
TB		Y N		Y N		Y N
STI		Y N		Y N		Y N
Diabetes		Y N		Y N		Y N
Lifestyle risk assessment						
Alcohol		Y N		Y N		Y N
Smoke/tobacco		Y N		Y N		Y N
Physical activity		Y N		Y N		Y N
Healthy eating		Y N		Y N		Y N
Sexual behaviour		Y N		Y N		Y N
Mental health		Y N		Y N		Y N
Known conditions *(Please tick)*	**Heart disease** **Hypertension** **Diabetes** **Asthma/COPD**					
	Other		Specify			
HIV		Y N		Y N		Y N
WHO stage						
Viral load						
CD4						
On ART		Y N		Y N		Y N
TB	**Intensive phase** **Continuation phase**		**Intensive phase** **Continuation phase**		**Intensive phase** **Continuation phase**	
Adherence to medication and pill count		Y N		Y N		Y N
Side effects to medication						
Other hospital/doctor visits						
Presenting complaints (Symptoms, duration, severity)						

CLINICAL MANAGEMENT

Visit number	7	8	9
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

CLINICAL MANAGEMENT

Visit number	10	11	12
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Vital signs			
Weight			
Height			
BMI			
Temperature			
Pulse			
Blood pressure			
Blood glucos			
Urine			
Basic screening			
HIV	Y N	Y N	Y N
TB	Y N	Y N	Y N
STI	Y N	Y N	Y N
Diabetes	Y N	Y N	Y N
Lifestyle risk assessment			
Alcohol	Y N	Y N	Y N
Smoke/tobacco	Y N	Y N	Y N
Physical activity	Y N	Y N	Y N
Healthy eating	Y N	Y N	Y N
Sexual behaviour	Y N	Y N	Y N
Mental health	Y N	Y N	Y N
Known conditions *(Please tick)*	**Heart disease** **Hypertension** **Diabetes** **Asthma/COPD**		
	Other	Specify	
HIV	Y N	Y N	Y N
WHO stage			
Viral load			
CD4			
On ART	Y N	Y N	Y N
TB	Intensive phase / Continuation phase	Intensive phase / Continuation phase	Intensive phase / Continuation phase
Adherence to medication and pill count	Y N	Y N	Y N
Side effects to medication			
Other hospital/doctor visits			
Presenting complaints (Symptoms, duration, severity)			

CLINICAL MANAGEMENT

Visit number	10	11	12
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

CLINICAL MANAGEMENT

Visit number	13		14		15	
Date of visit	d d m m y y y y		d d m m y y y y		d d m m y y y y	
Vital signs						
Weight						
Height						
BMI						
Temperature						
Pulse						
Blood pressure						
Blood glucos						
Urine						
Basic screening						
HIV		Y N		Y N		Y N
TB		Y N		Y N		Y N
STI		Y N		Y N		Y N
Diabetes		Y N		Y N		Y N
Lifestyle risk assessment						
Alcohol		Y N		Y N		Y N
Smoke/tobacco		Y N		Y N		Y N
Physical activity		Y N		Y N		Y N
Healthy eating		Y N		Y N		Y N
Sexual behaviour		Y N		Y N		Y N
Mental health		Y N		Y N		Y N
Known conditions *(Please tick)*	**Heart disease** **Hypertension** **Diabetes** **Asthma/COPD**					
	Other		Specify			
HIV		Y N		Y N		Y N
WHO stage						
Viral load						
CD4						
On ART		Y N		Y N		Y N
TB	Intensive phase / Continuation phase		Intensive phase / Continuation phase		Intensive phase / Continuation phase	
Adherence to medication and pill count		Y N		Y N		Y N
Side effects to medication						
Other hospital/doctor visits						
Presenting complaints (Symptoms, duration, severity)						

CLINICAL MANAGEMENT

Visit number	13	14	15
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

CLINICAL MANAGEMENT

Visit number	16		17		18	
Date of visit	d d m m y y y y		d d m m y y y y		d d m m y y y y	
Vital signs						
Weight						
Height						
BMI						
Temperature						
Pulse						
Blood pressure						
Blood glucos						
Urine						
Basic screening						
HIV		Y N		Y N		Y N
TB		Y N		Y N		Y N
STI		Y N		Y N		Y N
Diabetes		Y N		Y N		Y N
Lifestyle risk assessment						
Alcohol		Y N		Y N		Y N
Smoke/tobacco		Y N		Y N		Y N
Physical activity		Y N		Y N		Y N
Healthy eating		Y N		Y N		Y N
Sexual behaviour		Y N		Y N		Y N
Mental health		Y N		Y N		Y N
Known conditions *(Please tick)*	**Heart disease** **Hypertension** **Diabetes** **Asthma/COPD**					
	Other		Specify			
HIV		Y N		Y N		Y N
WHO stage						
Viral load						
CD4						
On ART		Y N		Y N		Y N
TB	Intensive phase / Continuation phase		Intensive phase / Continuation phase		Intensive phase / Continuation phase	
Adherence to medication and pill count		Y N		Y N		Y N
Side effects to medication						
Other hospital/doctor visits						
Presenting complaints (Symptoms, duration, severity)						

CLINICAL MANAGEMENT

Visit number	16	17	18
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

CLINICAL MANAGEMENT

Visit number	19								20								21							
Date of visit	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y
Vital signs																								
Weight																								
Height																								
BMI																								
Temperature																								
Pulse																								
Blood pressure																								
Blood glucos																								
Urine																								
Basic screening																								
HIV							Y	N							Y	N							Y	N
TB							Y	N							Y	N							Y	N
STI							Y	N							Y	N							Y	N
Diabetes							Y	N							Y	N							Y	N
Lifestyle risk assessment																								
Alcohol							Y	N							Y	N							Y	N
Smoke/tobacco							Y	N							Y	N							Y	N
Physical activity							Y	N							Y	N							Y	N
Healthy eating							Y	N							Y	N							Y	N
Sexual behaviour							Y	N							Y	N							Y	N
Mental health							Y	N							Y	N							Y	N
Known conditions *(Please tick)*	**Heart disease**				**Hypertension**				**Diabetes**				**Asthma/COPD**											
	Other								Specify															
HIV							Y	N							Y	N							Y	N
WHO stage																								
Viral load																								
CD4																								
On ART							Y	N							Y	N							Y	N
TB	Intensive phase				Continuation phase				Intensive phase				Continuation phase				Intensive phase				Continuation phase			
Adherence to medication and pill count							Y	N							Y	N							Y	N
Side effects to medication																								
Other hospital/doctor visits																								
Presenting complaints (Symptoms, duration, severity)																								

CLINICAL MANAGEMENT

Visit number	19	20	21
Date of visit	d d m m y y y y	d d m m y y y y	d d m m y y y y
Examination			
General			
Chest			
Cardio vascular			
Abdomen			
Mental state			
Diagnosis			
Management plan			
Investigations/tests requested			
Health education provided			
Treatment prescribed			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for each pregnancy

Obstetric History

Year	Gestation age	Delivery mode *NV=Normal Vaginal* *FS=Forceps* *VE=Vacuum Extraction* *CS=Caesarean Section*	Birth weight of baby	Pregnancy outcome *A = Alive* *ID = Infant death* *NND = Neonatal death* *IUD = Intra-uterine Death*

Previous Obstetric and Family History

Twins	Y	N	Genetic conditions	Y	N	Congenital defects	Y	N	Diabetes	Y	N	Hypertension	Y	N	Intra-uterine growth retardation	Y	N		
Antepartum haemorrhage				Y	N	Post partum haemorrhage				Y	N	Preterm labour	Y	N	Other (Specify)				

Gestational Age

LMP				**Certain?**	Y	N			
Expected date of delivery	d	d	m	m	y	y	y	y	

General Examination

Thyroid		BMI	
Urine		Heart	
Lungs		Breasts	
Height		Other	
Weight			

Abdomen

FHH Measurement	cm		Correlates with dates?	Y	N
Lie			Presentation		

Vaginal Examination

	Done	Not done	If not done, reasons?
Vulva and Vagina			
Cervix			
Uterus			

HIV Status

Known HIV positive	Y	N												
If Yes (Please tick)	Never on ART			Currently on ART			Previously on ART							
If currently on ART	Viral load				Regime									
If previously on ART; Defaulted	Y	N												
If defaulted, last date that ART medication was taken and ART regime	Date	d	d	m	m	y	y	y	y	Regime				
HIV test done today	Y	N	Results	POS	NEG									
CD4 Count		CPT	Y	N	IPT	Y	N							

BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for each pregnancy

Risk Screening

Patient referred to higher level	Y	N
Age < 16	Y	N
Age > 40 years	Y	N
Previous still birth or neonatal loss?	Y	N
History of 3 or more consecutive spontaneous abortions	Y	N
Birth weight of last baby < 2500g?	Y	N
Birth weight of last baby > 4500g?	Y	N
Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?	Y	N
Diastolic blood pressure 90 mmHg or more at booking	Y	N
Known 'substance' abuse (including heavy alcohol drinking)	Y	N
Any other severe ongoing disease or condition? e.g HT	Y	N
Vaginal bleeding	Y	N
Diagnosed or suspected multiple pregnancy	Y	N
Isoimmunisation Rh (-) previous pregnancy	Y	N
Previous surgery on reproductive tract	Y	N

IF YES, PLEASE SPECIFY *If one risk factor is identified above, refer patient to a higher level of care.*

Investigations

Pap Smear done	Y	N	Date	d	d	m	m	y	y	y	y	Result							
Rapid syphilis test												Pos	Neg	Repeat syphilis test			Pos	Neg	
RPR (titre)												TPHA							
Rhesus														Antibodies			Y	N	
Creatinine														ALT					
Haemoglobin							g/dl					Blood pressure							
Tetanus toxoid (date given)	1st																		
	d	d	m	m	y	y	y	y											
	2nd																		
	d	d	m	m	y	y	y	y											
	3rd																		
	d	d	m	m	y	y	y	y											

GENERAL MEDICAL AND SOCIAL INFORMATION: REFER TO PATIENT PROFILE

Management plan

Investigations/tests required	
Health education provided	
Treatment prescribed	
Unit identified for delivery	
Referral	
Date of next visit	d d m m y y y y

Health Care Practitioner	
Name	
Surname	
Signature	
SANC/HPCSA No	

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	<14		20		30		34	
	Date	d d m m y y y y		d d m m y y y y		d d m m y y y y		d d m m y y y y	
General Examination	Blood pressure								
	Maternal weight								
	Haemoglobin test								
	Bloodglucose (If applicable)								
	Urine test (result)								
	Clinical examination for anaemia								
Abdominal Examination	Fundus height (cm)								
	Lie								
	Presentation								
	Fetal heart rate								
	Fetal movements	Y	N	Y	N	Y	N	Y	N
	Detection of breech							Y	N
Supplements Given	Iron and folate supplementation	Y	N	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N	Y	N
Health Education	Information on emergencies given	Y	N	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N	Y	N
	Advice on lactation and contraception					Y	N	Y	N
	Reminder to bring card when in labour							Y	N
Health Care Practitioner	Name								
	Surname								
	Signature								
	SANC/HPCSA No								

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date d d m m y y y y	**Place of birth**				
Birth weight		**Birth length**			
Apgar	1 minute			5 minutes	
Delivery mode *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	**NV**	**FS**	**VE**	**CS**	**Comments**
Pregnancy outcome *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-uterine Death)*	**A**	**ID**	**NND**	**IUD**	**Comments**
Comment on birth and/or delivery					
Health Care Practitioner	Name and surname				
	Signature				
	SANC/HPCSA No				

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	36		38		40	
	Date	d d m m y y y y		d d m m y y y y		d d m m y y y y	
General Examination	Blood pressure						
	Maternal weight						
	Haemoglobin test						
	Bloodglucose (If applicable)						
	Urine test (result)						
	Clinical examination for anaemia						
Abdominal Examination	Fundus height (cm)						
	Lie						
	Presentation						
	Fetal heart rate						
	Fetal movements	Y	N	Y	N	Y	N
	Detection of breech						
Supplements Given	Iron and folate supplementation	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N
Health Education	Information on emergencies given	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N
	Advice on lactation and contraception					Y	N
	Reminder to bring card when in labour						
Health Care Practitioner	Name						
	Surname						
	Signature						
	SANC/HPCSA No						

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date d d m m y y y y		**Place of birth**			
Birth weight			**Birth length**		
Apgar		1 minute			5 minutes
Delivery mode *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	**NV**	**FS**	**VE**	**CS**	**Comments**
Pregnancy outcome *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-uterine Death)*	**A**	**ID**	**NND**	**IUD**	**Comments**
Comment on birth and/or delivery					
Health Care Practitioner	Name and surname				
	Signature				
	SANC/HPCSA No				

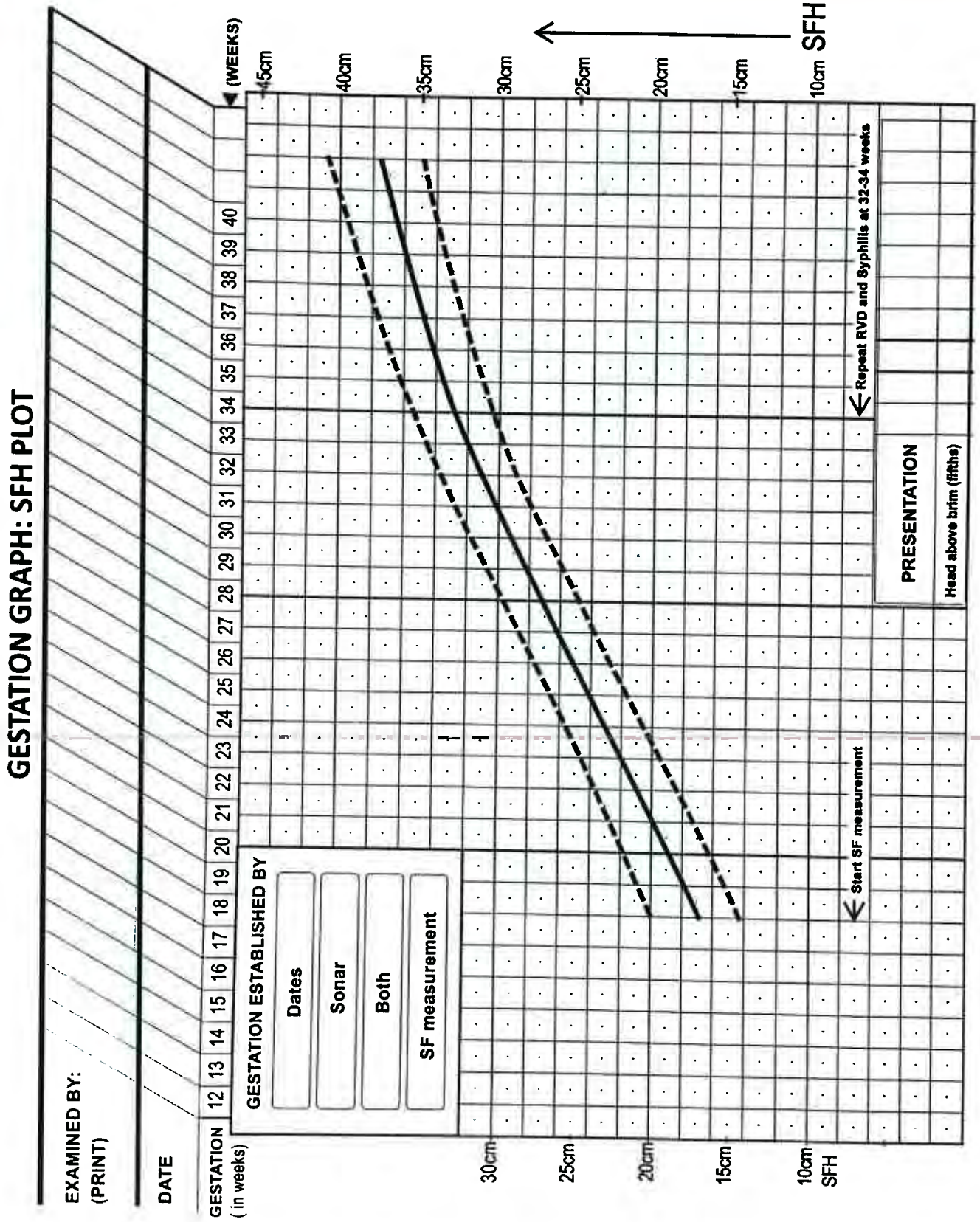
POSTNATAL CARE

Complete this form the first time a pregnant woman presents for antenatal care for the pregnanc

General Examination		3 – 6 Days	6 week after delivery
	Date	d d m m y y y y	d d m m y y y y
	Blood pressure		
	Temperature		
	Pulse		
	Urine test		
	Fundal height		
	Urinary problems / micturition		
	Vaginal bleeding : amount, colour and odour		
	Perineum		
	Haemorrhoids		
	Signs of thrombosis		
	Breasts problems		
	Signs of infections		
	Haemoglobin		
	Emotional status		

Management Plan		
	3 – 6 Days	6 week after delivery
Investigations/tests requested		
Health education provided (include nutrition, signs of complications)		
Treatment prescribed (include Vitamin A, TT3)		
Contraceptive method		
Feeding method of choice		
Referral		
Next Visit	d d m m y y y y	d d m m y y y y
Health Care Practitioner		
Name		
Surname		
Signature		
SANC/HPCSA No		

GESTATIONAL GRAPH PLOT DURING PREGNANCY



BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for each pregnancy

Obstetric History

Year	Gestation age	Delivery mode *NV=Normal Vaginal* *FS=Forceps* *VE=Vacuum Extraction* *CS=Caesarean Section*	Birth weight of baby	Pregnancy outcome *A = Alive* *ID = Infant death* *NND = Neonatal death* *IUD = Intra-uterine Death*

Previous Obstetric and Family History

Twins	Y	N	Genetic conditions	Y	N	Congenital defects	Y	N	Diabetes	Y	N	Hypertension	Y	N	Intra-uterine growth retardation	Y	N		
Antepartum haemorrhage				Y	N	Post partum haemorrhage				Y	N	Preterm labour	Y	N	Other (Specify)				

Gestational Age

LMP				**Certain?**	Y	N			
Expected date of delivery	d	d	m	m	y	y	y	y	

General Examination

Thyroid		BMI	
Urine		Heart	
Lungs		Breasts	
Height		Other	
Weight			

Abdomen

FHH Measurement	cm	Correlates with dates?	Y N
Lie		Presentation	

Vaginal Examination

	Done	Not done	If not done, reasons?
Vulva and Vagina			
Cervix			
Uterus			

HIV Status

Known HIV positive	Y	N											
If Yes (Please tick)	Never on ART			Currently on ART				Previously on ART					
If currently on ART	Viral load				Regime								
If previously on ART; Defaulted	Y	N											
If defaulted, last date that ART medication was taken and ART regime	Date			d	d	m	m	y	y	y	y	Regime	
HIV test done today	Y	N		Results		POS	NEG						
CD4 Count		CPT		Y	N	IPT	Y	N					

BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for each pregnancy

Risk Screening

Patient referred to higher level	Y	N
Age < 16	Y	N
Age > 40 years	Y	N
Previous still birth or neonatal loss?	Y	N
History of 3 or more consecutive spontaneous abortions	Y	N
Birth weight of last baby < 2500g?	Y	N
Birth weight of last baby > 4500g?	Y	N
Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?	Y	N
Diastolic blood pressure 90 mmHg or more at booking	Y	N
Known 'substance' abuse (including heavy alcohol drinking)	Y	N
Any other severe ongoing disease or condition? e.g HT	Y	N
Vaginal bleeding	Y	N
Diagnosed or suspected multiple pregnancy	Y	N
Isoimmunisation Rh (-) previous pregnancy	Y	N
Previous surgery on reproductive tract	Y	N

IF YES, PLEASE SPECIFY *If one risk factor is identified above, refer patient to a higher level of care.*

Investigations

Pap Smear done	Y	N	Date	d	d	m	m	y	y	y	y	Result					
Rapid syphilis test								Pos		Neg		Repeat syphilis test			Pos		Neg
RPR (titre)								TPHA									
Rhesus												Antibodies			Y		N
Creatinine												ALT					
Haemoglobin						g/dl		Blood pressure									
Tetanus toxoid (date given)	1st								2nd								
	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y	
	3rd																
	d	d	m	m	y	y	y	y									

GENERAL MEDICAL AND SOCIAL INFORMATION: REFER TO PATIENT PROFILE

Management plan

Investigations/tests required	
Health education provided	
Treatment prescribed	
Unit identified for delivery	
Referral	
Date of next visit	d d m m y y y y

Health Care Practitioner	
Name	
Surname	
Signature	
SANC/HPCSA No	

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	<14		20		30		34	
	Date	d d m m y y y y		d d m m y y y y		d d m m y y y y		d d m m y y y y	
General Examination	Blood pressure								
	Maternal weight								
	Haemoglobin test								
	Bloodglucose (If applicable)								
	Urine test (result)								
	Clinical examination for anaemia								
Abdominal Examination	Fundus height (cm)								
	Lie								
	Presentation								
	Fetal heart rate								
	Fetal movements	Y	N	Y	N	Y	N	Y	N
	Detection of breech							Y	N
Supplements Given	Iron and folate supplementation	Y	N	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N	Y	N
Health Education	Information on emergencies given	Y	N	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N	Y	N
	Advice on lactation and contraception					Y	N	Y	N
	Reminder to bring card when in labour							Y	N
Health Care Practitioner	Name								
	Surname								
	Signature								
	SANC/HPCSA No								

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date d d m m y y y y	**Place of birth**				
Birth weight		**Birth length**			
Apgar	1 minute			5 minutes	
Delivery mode *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	**NV**	**FS**	**VE**	**CS**	**Comments**
Pregnancy outcome *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-uterine Death)*	**A**	**ID**	**NND**	**IUD**	**Comments**
Comment on birth and/or delivery					
Health Care Practitioner	Name and surname				
	Signature				
	SANC/HPCSA No				

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	36		38		40	
	Date	d d m m y y y y		d d m m y y y y		d d m m y y y y	
General Examination	Blood pressure						
	Maternal weight						
	Haemoglobin test						
	Bloodglucose (If applicable)						
	Urine test (result)						
	Clinical examination for anaemia						
Abdominal Examination	Fundus height (cm)						
	Lie						
	Presentation						
	Fetal heart rate						
	Fetal movements	Y	N	Y	N	Y	N
	Detection of breech						
Supplements Given	Iron and folate supplementation	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N
Health Education	Information on emergencies given	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N
	Advice on lactation and contraception					Y	N
	Reminder to bring card when in labour						
Health Care Practitioner	Name						
	Surname						
	Signature						
	SANC/HPCSA No						

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date d d m m y y y y		**Place of birth**			
Birth weight		**Birth length**			
Apgar		1 minute		5 minutes	
Delivery mode *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	**NV**	**FS**	**VE**	**CS**	**Comments**
Pregnancy outcome *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-Uterine Death)*	**A**	**ID**	**NND**	**IUD**	**Comments**
Comment on birth and/or delivery					
Health Care Practitioner	Name and surname				
	Signature				
	SANC/HPCSA No				

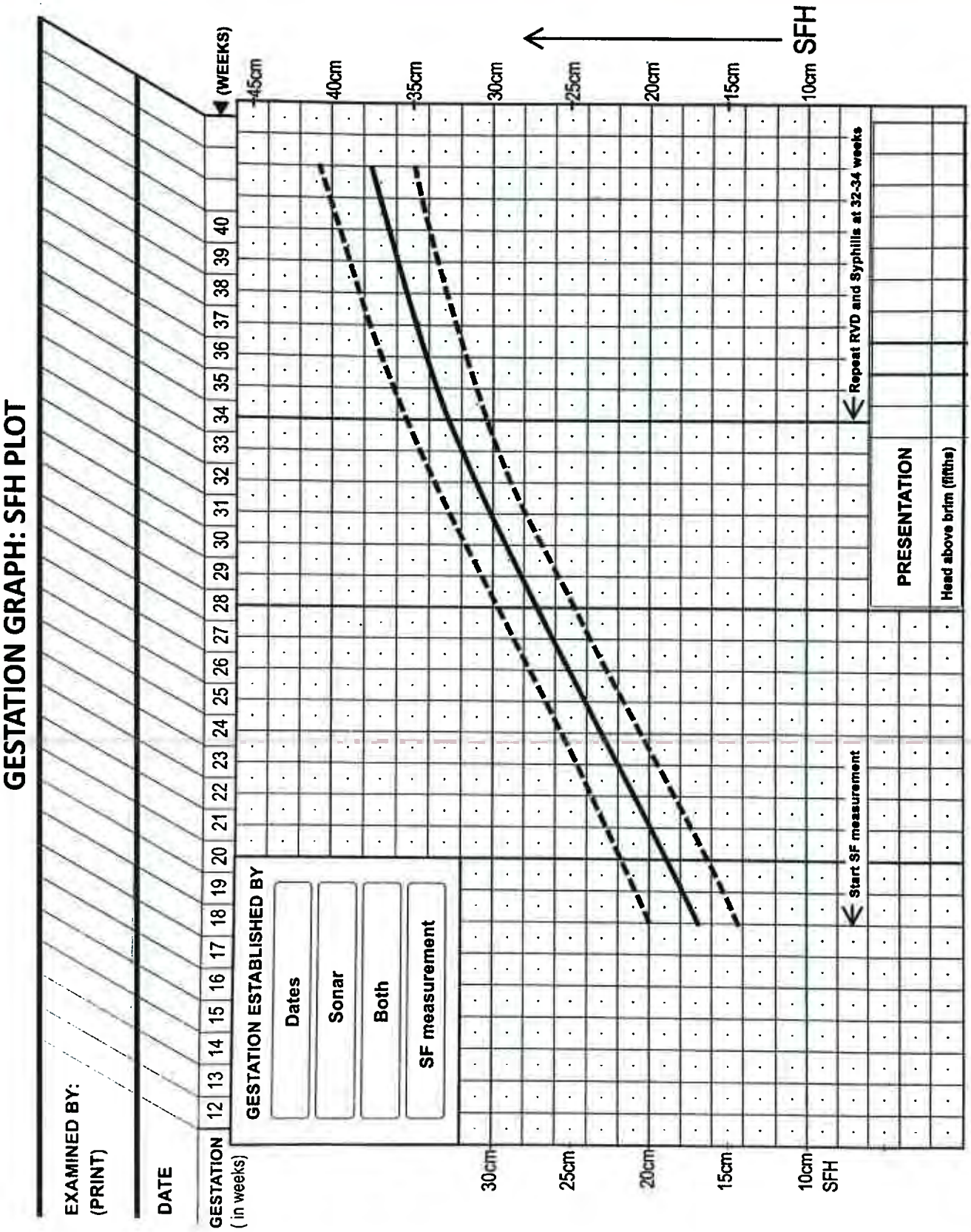
POSTNATAL CARE

Complete this form the first time a pregnant woman presents for antenatal care for the pregnanc

General Examination		3 – 6 Days	6 week after delivery
	Date	d d m m y y y y	d d m m y y y y
	Blood pressure		
	Temperature		
	Pulse		
	Urine test		
	Fundal height		
	Urinary problems / micturition		
	Vaginal bleeding : amount, colour and odour		
	Perineum		
	Haemorrhoids		
	Signs of thrombosis		
	Breasts problems		
	Signs of infections		
	Haemoglobin		
	Emotional status		

Management Plan		
	3 – 6 Days	6 week after delivery
Investigations/tests requested		
Health education provided (include nutrition, signs of complications)		
Treatment prescribed (include Vitamin A, TT3)		
Contraceptive method		
Feeding method of choice		
Referral		
Next Visit	d d m m y y y y	d d m m y y y y
Health Care Practitioner		
Name		
Surname		
Signature		
SANC/HPCSA No		

GESTATIONAL GRAPH PLOT DURING PREGNANCY



BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for each pregnancy

Obstetric History

Year	Gestation age	Delivery mode *NV=Normal Vaginal* *FS=Forceps* *VE=Vacuum Extraction* *CS=Caesarean Section*	Birth weight of baby	Pregnancy outcome *A = Alive* *ID = Infant death* *NND = Neonatal death* *IUD = Intra-uterine Death*

Previous Obstetric and Family History

Twins	Y	N	Genetic conditions	Y	N	Congenital defects	Y	N	Diabetes	Y	N	Hypertension	Y	N	Intra-uterine growth retardation	Y	N		
Antepartum haemorrhage				Y	N	Post partum haemorrhage				Y	N	Preterm labour	Y	N	Other (Specify)				

Gestational Age

LMP					**Certain?**	Y	N		
Expected date of delivery	d	d	m	m	y	y	y	y	

General Examination

Thyroid		BMI	
Urine		Heart	
Lungs		Breasts	
Height		Other	
Weight			

Abdomen

FHH Measurement	cm		Correlates with dates?	Y	N
Lie			Presentation		

Vaginal Examination

	Done	Not done	If not done, reasons?
Vulva and Vagina			
Cervix			
Uterus			

HIV Status

Known HIV positive	Y	N																	
If Yes (Please tick)	Never on ART				Currently on ART				Previously on ART										
If currently on ART	Viral load					Regime													
If previously on ART; Defaulted	Y	N																	
If defaulted, last date that ART medication was taken and ART regime	Date	d	d	m	m	y	y	y	y	Regime									
HIV test done today	Y	N	Results	POS	NEG														
CD4 Count		CPT	Y	N	IPT	Y	N												

BASIC ANTENATAL CARE ASSESSMENT - FIRST VISIT OF PREGNANCY

Complete this form the first time a pregnant woman presents for antenatal care for each pregnancy

Risk Screening

Patient referred to higher level	Y	N
Age < 16	Y	N
Age > 40 years	Y	N
Previous still birth or neonatal loss?	Y	N
History of 3 or more consecutive spontaneous abortions	Y	N
Birth weight of last baby < 2500g?	Y	N
Birth weight of last baby > 4500g?	Y	N
Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?	Y	N
Diastolic blood pressure 90 mmHg or more at booking	Y	N
Known 'substance' abuse (including heavy alcohol drinking)	Y	N
Any other severe ongoing disease or condition? e.g HT	Y	N
Vaginal bleeding	Y	N
Diagnosed or suspected multiple pregnancy	Y	N
Isoimmunisation Rh (-) previous pregnancy	Y	N
Previous surgery on reproductive tract	Y	N

IF YES, PLEASE SPECIFY *If one risk factor is identified above, refer patient to a higher level of care.*

Investigations

Pap Smear done	Y	N	Date	d	d	m	m	y	y	y	y	Result					
Rapid syphilis test								Pos	Neg	Repeat syphilis test					Pos	Neg	
RPR (titre)								TPHA									
Rhesus										Antibodies					Y	N	
Creatinine										ALT							
Haemoglobin					g/dl			Blood pressure									

Tetanus toxoid (date given)	1st								2nd								3rd						
	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y	d	d	m	m	y	y	y	y

GENERAL MEDICAL AND SOCIAL INFORMATION: REFER TO PATIENT PROFILE

Management plan

Investigations/tests required	
Health education provided	
Treatment prescribed	
Unit identified for delivery	
Referral	
Date of next visit	d d m m y y y y

Health Care Practitioner	
Name	
Surname	
Signature	
SANC/HPCSA No	

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	<14		20		30		34	
	Date	d d m m y y y y		d d m m y y y y		d d m m y y y y		d d m m y y y y	
General Examination	Blood pressure								
	Maternal weight								
	Haemoglobin test								
	Bloodglucose (If applicable)								
	Urine test (result)								
	Clinical examination for anaemia								
Abdominal Examination	Fundus height (cm)								
	Lie								
	Presentation								
	Fetal heart rate								
	Fetal movements	Y	N	Y	N	Y	N	Y	N
	Detection of breech							Y	N
Supplements Given	Iron and folate supplementation	Y	N	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N	Y	N
Health Education	Information on emergencies given	Y	N	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N	Y	N
	Advice on lactation and contraception					Y	N	Y	N
	Reminder to bring card when in labour							Y	N
Health Care Practitioner	Name								
	Surname								
	Signature								
	SANC/HPCSA No								

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date d d m m y y y y		**Place of birth**			
Birth weight		**Birth length**			
Apgar	1 minute		5 minutes		
Delivery mode *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	**NV**	**FS**	**VE**	**CS**	**Comments**
Pregnancy outcome *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-uterine Death)*	**A**	**ID**	**NND**	**IUD**	**Comments**
Comment on birth and/or delivery					
Health Care Practitioner	Name and surname				
	Signature				
	SANC/HPCSA No				

FOLLOW-UP ANTENATAL CARE VISITS

If the first visit is later than 12 weeks, all activities for the '<12' week visit should be undertaken at that time, regardless of gestation. Put date and for test the results

	Weeks	36		38		40	
	Date	d d m m y y y y		d d m m y y y y		d d m m y y y y	
General Examination	Blood pressure						
	Maternal weight						
	Haemoglobin test						
	Bloodglucose (If applicable)						
	Urine test (result)						
	Clinical examination for anaemia						
Abdominal Examination	Fundus height (cm)						
	Lie						
	Presentation						
	Fetal heart rate						
	Fetal movements	Y	N	Y	N	Y	N
	Detection of breech						
Supplements Given	Iron and folate supplementation	Y	N	Y	N	Y	N
	Calcium supplementation	Y	N	Y	N	Y	N
Health Education	Information on emergencies given	Y	N	Y	N	Y	N
	Antenatal card completed, given to woman	Y	N	Y	N	Y	N
	Contraception	Y	N	Y	N	Y	N
	Instructions given for delivery and transport					Y	N
	Advice on lactation and contraception					Y	N
	Reminder to bring card when in labour						
Health Care Practitioner	Name						
	Surname						
	Signature						
	SANC/HPCSA No						

Delivery Summary *(To be completed after delivery of this pregnancy)*

Birth Date d d m m y y y y		**Place of birth**			
Birth weight		**Birth length**			
Apgar	1 minute			5 minutes	
Delivery mode *(NV=Normal Vaginal FS=Forceps VE=Vacuum Extraction CS=Caesarean Section)*	**NV**	**FS**	**VE**	**CS**	**Comments**
Pregnancy outcome *(A=Alive ID= Infant death NND=Neonatal death IUD=Intra-uterine Death)*	**A**	**ID**	**NND**	**IUD**	**Comments**
Comment on birth and/or delivery					
Health Care Practitioner	Name and surname				
	Signature				
	SANC/HPCSA No				

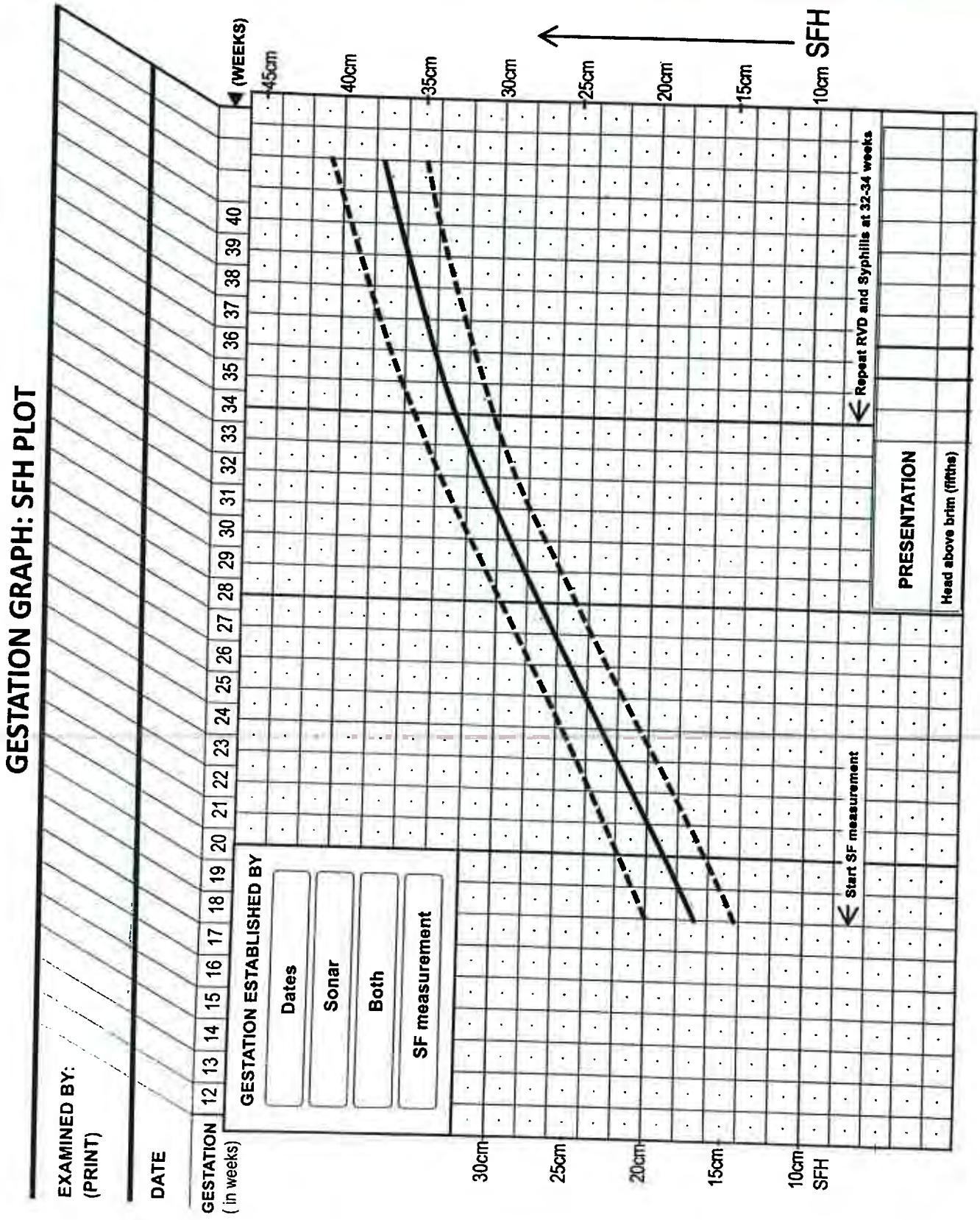
POSTNATAL CARE

Complete this form the first time a pregnant woman presents for antenatal care for the pregnanc

General Examination		3 – 6 Days	6 week after delivery
	Date	d d m m y y y y	d d m m y y y y
	Blood pressure		
	Temperature		
	Pulse		
	Urine test		
	Fundal height		
	Urinary problems / micturition		
	Vaginal bleeding : amount, colour and odour		
	Perineum		
	Haemorrhoids		
	Signs of thrombosis		
	Breasts problems		
	Signs of infections		
	Haemoglobin		
	Emotional status		

Management Plan		
	3 – 6 Days	6 week after delivery
Investigations/tests requested		
Health education provided (include nutrition, signs of complications)		
Treatment prescribed (include Vitamin A, TT3)		
Contraceptive method		
Feeding method of choice		
Referral		
Next Visit	d d m m y y y y	d d m m y y y y
Health Care Practitioner		
Name		
Surname		
Signature		
SANC/HPCSA No		

GESTATIONAL GRAPH PLOT DURING PREGNANCY



ORAL HEALTH CARE

MEDICAL HISTORY

		No	Yes	If Yes, provide details
1.	Rheumatic heart disease			
2.	Heart condition			
3.	Diabetes mellitus			
4.	High Blood Pressure			
5.	Epilepsy			
6.	Porphyria			
7.	Allergy			
8.	Radiation treatment			
9.	Breathing difficulty			
10.	Pregnancy			
11.	Other; specify			

DENTAL STATUS AND TREATMENT NEED

STATUS

0. Sound
1. Decayed
2. Filled & decayed
3. Filled; no decay
4. Missing due to caries
5. Missing, any other reason
6. Sealant
7. Bridge abutment/Special Crown
8. Unerupted/Impacted tooth
9. Perio/Mobile tooth
10. Malocclusion
11. Fractured Crown

TREATMENT NEED

0. None
1. Caries arresting/ sealant care
2. One surface filling
3. Two or more surface filling
4. Pulp care
5. Extraction
6. Surgical removal
7. Dentures
8. Orthodontic referral

Signature of Patient _____ **Date** _____

ADULT DENTAL RECORD

TREATMENT PLAN Nr.....

ADULT DENTITION

DENTITION	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
STATUS																
TREATMENT NEED																
STATUS																
TREATMENT NEED																
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

TREATMENT		Health Care worker		
Date	Procedure	Name	Surname	Signature

REFERRAL		Health Care worker		
Date	Reasons	Name	Surname	Signature
Signature Patient		Date		

ADULT DENTAL RECORD

TREATMENT PLAN Nr.....

ADULT DENTITION

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TREATMENT		Health Care worker		
Date	Procedure	Name	Surname	Signature

REFERRAL		Health Care worker		
Date	Reasons	Name	Surname	Signature
Signature Patient		Date		

REHABILITATION - FIRST VISIT

Date of visit	
Presenting condition	
Condition	
Assessment	
Management plan	
Rehabilitation plan	
Assistive devices required	
Referral	
Other consideration/enabling factors (including health needs)	
Health Care Practitioner	
Name	
Surname	
Signature	
SANC/HPCSA No	

REHABILITATION - SUBSEQUENT VISITS

Date of visit			
Presenting condition			
Key observations			
Outcomes			
Management plan			
Treatment prescribed			
Health education provided			
Referral			
Next visit in	weeks	weeks	weeks
Health Care Practitioner/ Team members			
Name/s			
Surname/s			
Signature			
SANAC/HPCSA No			
Discharge report			
Discharge notes			
Next visit in	weeks		
Health Care Practitioner			
Name			
Surname			
Signature			
SANC/HPCSA No			

REHABILITATION - SUBSEQUENT VISITS

Date of visit			
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LABORATORY TEST RESULTS

TEST	Date requested d d m m y y y y	Date requested d d m m y y y y	Date requested d d m m y y y y	Date requested d d m m y y y y
	Results	Results	Results	Results
ALP				
ALT				
Calcium				
CD4				
Cholesterol				
Coomb's Test				
CRAG (Cryptococcal antigen test)				
Creatinine (eGFR)				
CPR				
Cytology				
Differential count				
FT4 (Free Thyroxine 4)				
Gamma GT				
Haemoglobin				
HbA1c				
Hepatitis A, B or C				
HIV PCR for infants				
INR				
Lactic Acid				
LDL				
Lipase				
MCS (Non-TB)				
MCV				
Pap smear				
Phenytoin				
Platelets				
Potassium				
PSA				
Red Cell Folate				
RPR				
Sodium				
Stool parasites				
TB Drug Susceptibility				
TB Line Probe Assay				
TB MC&S (re-treatment and HIV patients)				
Triglycerides				
TSH				
Uric Acid (Serum)				
Urine albumin: creatinine ratio				
Urine protein: creatinine ratio				
Viral load				
Vitamin B12				
WBC				
Xpert MTB/RIF				
Other				

LABORATORY TEST RESULTS

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PRESCRIPTION

PATIENT'S NAME AND SURNAME														
ID													**AGE**	
ALLERGIES														

Date	**DETAILS OF PRESCRIPTION** Print the name and dosage of the drugs in the blocks below **- NOTE ONE ITEM PER BLOCK**		1 of 6 (Initial)	2 of 6	3 of 6	**REPEATS** 4 of 6	5 of 6	6 of 6
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
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V3/2017

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		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						
		Date						
		Quantity						
	or equivalent	Batch No						
		Dispenser Signature						
	Prescriber name, signature & qualifications	Print Name						

TB ADHERENCE

If patient was not diagnosed on sputum, indicate other method of diagnosis

CSF | X-Ray | Aspiration/Biopsy | Mantoux: .....mm

Patient Category

N New patient

RC Relapse (retreatment after cure)

RF Re-treatment after failure

RD Retreatment after default

OR All other Re-treatment cases not included in above categories

Classification of Disease

ICD10 Code (According to list in back of TB register) _____

Pulmonary TB | Both

Extra PTB | Site Extra PTB _____

Multidisciplinary team

Placed out

If no, reason _____

Self-Supervised	Workplace	Clinic

Name of Community Health Worker

Date

Treatment

Intensive Phase (IP)

Drug	RHZE	60/60	Z	E	Other
Dosage					

Body weight at start of IP	

Month	Date	No of Doses taken

✓ = patient took medication

✗ = patient did not take medication

— = medication collected for self administration or supervision elsewhere

Health Care Practitioner

Name

Surname

Signature

SANC/HPCSA No

TB ADHERENCE

Continuous phase (CP)

Drug	RHZE	60/60	Z	E	Other
Dosage					
Body weight at start of CP					

Month	Date	No of Doses taken

✓ = patient took medication
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TREATMENT SUPERVISOR

Name _____ Tel/Cellphone _____

Address _____

Close Contacts

	Age	Screened		IPT started		TB treatment started	
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N

Treatment Outcomes

Treatment stop date	d d m m y y y y				
Outcome	Cured	Treatment completed	Treatment defaulted	Treatment failure	Died

Cured – Patient initially smear -ve at or 1 month prior to completion of treatment & on at least one previous occasion
Treatment completed – Patient has completed treatment but does not have bacteriological proof of cure
Defaulted treatment – Patient whose treatment is interrupted for 2 consecutive months or more
Failed treatment – Patient who remained smear+ at 5 months during treatment
Died – Patient who died for any reason during TB treatment

Referrals

☐ **Moved** (Patient moved to another facility in the same sub-district)

☐ **Transferred out** (Patient transferred to another sub-district, district, province)

Facility _____ Sub-district/District _____

Province _____ Country _____

Health Care Practitioner

Name	
Surname	
Signature	
SANC/HPCSA No	

TB ADHERENCE

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CSF | X-Ray | Aspiration/Biopsy | Mantoux: .....mm

Patient Category

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ICD10 Code (According to list in back of TB register) _____

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Extra PTB | Site Extra PTB _____

Multidisciplinary team

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If no, reason _____

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		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
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		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N
		Y	N	Y	N	Y	N

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		Y	N	Y	N	Y	N
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Facility _____ Sub-district/District _____

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Health Care Practitioner

Name

Surname

Signature

SANC/HPCSA No

CONSENT FOR HIV TESTING/OTHER PROCEDURES

I, _____ the undersigned, hereby provide consent to the health care practitioner for

1. Voluntary HIV testing

I understand that the results will be kept confidential.

2. Other procedure _____

_____

_____

(a) The advantages and possible complications have been explained to me.

(b) I also understand that in case of any complications as explained to me, I should come back to the facility for consultation.

_____ d d – m m – y y y y

Patient's Signature/Right Thumb Print Date

_____ d d – m m – y y y y

Health Care Practitioner's Signature Date

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_____
Patient's Signature/Right Thumb Print

d d – m m – y y y y
Date

_____
Health Care Practitioner's Signature

d d – m m – y y y y
Date

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_____
Patient's Signature/Right Thumb Print

d d – m m – y y y y
Date

_____
Health Care Practitioner's Signature

d d – m m – y y y y
Date

DEPARTMENT OF HEALTH

Patient File Number:

			–				–				

ID/Passport Number:

HPRS LABEL .....

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

ADULT FEMALE PATIENT HEALTH RECORD
PRIMARY HEALTH CARE

ADULT FEMALE PATIENT HEALTH RECORD:

PRIMARY HEALTH CARE

Name: _____

Surname: _____

Facility Name: _____

Facility unique number: _____

Folders Specs:T

EXT: White Bond 70gsm (80gsm also fine if 70mgs not available)
COVER: Sinavendar Board 230gsm

Size : 275x210mm
POCKET : 165x215mm
Print : Text Web printed in black colours throughout. Cover litho printed in four process colours plus overall matt machine varnish one side only and scored. Pocket plain not printed die cut to shape and size. Folded, collated, perfect bound, cover drawn on and trimmed flush. Adhere pocket to inside of back cover with twinstix.

Packed 85 per box.
Client to provide : X1A PDF File (Patient Folder Artwork) to be supplied to Supplier with colour lasers