FORM 1: ADULT PATIENT REGISTRATION

(Form filled in by Admin Clerk/Data Capturer)

South African ID Number: | **Province:** N L | **Registration Date:** d d / m m / y y y y

Patient Firstname: | **Patient Surname:**

Middle Names: | **Hospital File Number:** *(if relevant)* | **Site Code:** | **Capturer:**

Funding/Billing: ○ Government ○ Private/Other *(Specify):*

A. PATIENT DETAILS

1. Date of Birth: d d / m m / y y y y

2. Gender: ○ Male ○ Female

3. Population Group: ○ Black ○ Coloured ○ Indian ○ White ○ Other *(Specify):*

4. Citizenship/Residence Status: ○ South African ○ Other *(Specify):*

5. Home Language: ○ Zulu ○ Xhosa ○ Sotho ○ English ○ Afrikaans ○ Other *(Specify):*

6. English Ability: ○ Understand ○ Speak Little ○ Speak Well ○ Read ○ No English Ability
(Fill all that apply)

7. Marital Status: ○ Single ○ Married ○ Cohabiting

8. Referred By: ○ VCT Site ○ Self-Referral ○ Inpatient ○ Traditional Healer ○ PMTCT Site ○ TB Clinic ○ Outpatient ○ Other *(Specify):*

8a. If Referred by VCT Site then Date of VCT: d d / m m / y y y y

8b. Place where VCT was done:

B. CONTACT DETAILS

1. Primary Address: *(Physical Address or Directions)*

Area:

Postal Code: | **District Code:**

(Only enter numbers - No brackets or dashes)

2. Tel (home):

3. Tel (work):

4. Tel (cell):

5. Tel (other):

C. ALTERNATIVE ADDRESS

1. Do you have another address that you visit regularly? ○ Yes ○ No

1a. If so, when do you go?

○ Monthly ○ Twice a year ○ Quarterly ○ Annually

○ Other *(Specify)*

1b. How long do you go for?

○ Less than a month

○ More than a month *(Specify)* →

1c. Directions to your alternative address:

D. TRAVEL AND DISTANCE

1. How long does it take for you to come from home to the hospital:

○ Less than 30mins ○ 30mins to 1hr ○ 1hr to 2hrs ○ More than 2hrs

1a. What will be your usual means of coming to the hospital: *(Fill all that apply)* ○ Bus ○ Car ○ Taxi ○ Train ○ Walk

1b. What is the name of the nearest clinic to where you live:

E. CONTACT PERSONS

1. Who is your primary contact person/next of kin?

Name:

Address:

Area:

Postal Code **District Code**

Tel No:

How are they related to you?

○ Partner
○ Family Member
○ Household Member
○ Friend
○ Health Care Provider
○ Employer
○ Other *(Specify)* →

HIV status disclosed to this person? ○ Yes ○ No

2. Who is your alternative contact person/next of kin?

Name:

Address:

Area:

Postal Code **District Code**

Tel No:

How are they related to you?

○ Partner
○ Family Member
○ Household Member
○ Friend
○ Health Care Provider
○ Employer
○ Other *(Specify)* →

HIV status disclosed to this person? ○ Yes ○ No

F. DISCLOSURE

1. Have you disclosed your HIV status to anyone? *(Include the contacts given in section E)* ○ Yes ○ No

If Yes, please fill in the table below:

Disclosed To (Fill all that apply)	Supportive		Treatment Buddy		Disclosed To (Fill all that apply)	Supportive		Treatment Buddy	
	Yes	No	Yes	No		Yes	No	Yes	No
Partner	○	○	○	○	Health Care Provider	○	○	○	○
Family Member	○	○	○	○	Employer	○	○	○	○
Household Member	○	○	○	○	Other:	○	○	○	○
Friend	○	○	○	○	Other:	○	○	○	○

G. SOCIAL SECURITY GRANTS

1. Have you ever attended school? ○ Yes ○ No

1a. If so, what level of education do you have? *(Not Matric)* ○ Primary ○ High School ○ Matric ○ Tertiary

2. Are you currently employed? ○ Yes ○ No

3. How many adult dependents are living in your home? [ ][ ] *(Unemployed Adults)*

4. How many child dependents are living in your home? [ ][ ]

4a. How many have been tested for HIV? [ ][ ]

4b. How many are HIV positive? [ ][ ]

4c. How many are on ARV Treatment? [ ][ ]

5. Are you the recipient of a Social Security Grant(s)? ○ Yes ○ No *(If in doubt refer to a social worker - Question 5b)*

5a. If Yes, what type of Grant(s) do you receive?

○ Old Age Grant ○ Care Dependency Grant

○ Disability Grant ○ Child Support Grant → [ ][ ] *(Specify for how many children)*

○ Social Relief of Distress Grant ○ Foster Care Grant → [ ][ ] *(Specify for how many children)*

5b. Refer to a social worker? ○ Yes ○ No *(For Grant Application/Home Affair Assistance)*

H. DOMESTIC FACILITES

1. What type of Water Supply do you have in your home? ○ Piped Water in Home ○ Communal Tap ○ Surface Water

2. What type of Sanitation do you have at home? ○ Flushing Toilet ○ VIP *(Non-Flushing Outside Toilet)*

3. Do you have Electricity in your home? ○ Yes ○ No

4. What kind of Cooking Facilities do you use at home? ○ Wood ○ Gas ○ Paraffin ○ Electrical Stove

Positive Living Date: *(Patient Literacy 1)* [d][d] / [m][m] / [y][y][y][y] **Time:** [h][h] : [m][m] *(24 hrs - eg. 13:30)*