Consent to Treatment Initiation

The form below is to be completed by any Ubuntu client:

- Being initiated on ART treatment
- Transferring treatment from a local clinic to Ubuntu Education Fund's clinic

Policies

Transfer In's/Outs:

1) If referred in from other clinic, the Clinical Manager or nurse must call the referral clinic and get input on the client's previous adherence history which will go in the client's ACR file at Ubuntu.
2) Clinical staff must be aware of this history and work to improve or maintain adherence.
3) If a client is transferring out, the Clinical Manager or nurse must call the transfer clinic and connect with someone to follow up to make sure the client came to get medication.

Authorized Contacts:

1) The client initiating treatment must identify two individuals that may fetch treatment for them in an emergency or in case of employment by the client (details to be recorded below).
2) These individuals may not be school going children under the age of 21.
3) Persons identified by the client are required to come to Ubuntu and sign the treatment supporter form attached to this document. This form indicates the authorized supporters have been made aware of this set up by the client and understand the process and what is required for treatment collection at Ubuntu.
4) If a client is under 12 years of age the primary caregiver must complete this form.

*** ***The staff member completing this form is required to call both contact #'s while the client is present to ensure that they are working*** ***

Disclosure:

1) If the individual has not disclosed to anyone, they must go through the disclosure process and attend either the program or if the program is not running, meet weekly with case worker until they have disclosed to one person by the end of the 2 month period.

Adherence counseling/education to be provided same day client is initiated/ transferred at Ubuntu
Adherence package to be provided for adherence support

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Authorized Contacts Consent

I (first name) _____ (surname) _____ (case number) - _____ consent to allowing the following individuals to (*please select*): ☐ pickup my medication **AND/OR** ☐ send the following people with my child that is under 12 years of age to Ubuntu clinic to fetch their medication. I understand that I should only send these individuals in a case of emergency or in the event that I am unable to come to Ubuntu clinic due to illness or employment.

I also consent to the understanding that I am required to come to the Ubuntu Clinic monthly to have my vitals monitored if I am unable to regularly fetch my medication.

Umna……ndinikeza imvume kwababantu balandelayo ukuba bandithathele amayeza okanye bandizisele umntwana wam oneminyaka engaphantsi ku-12 ekliniki e-Ubuntu xa kuthe kwavela into engxamisekileyo ebangela ukuba ndingakwazi ukuza e-Ubuntu Kliniki.

Client Signature……Date……

Has Client Disclosed? ☐ Yes ☐ No	**Is client under 12 years of age?** ☐ Yes ☐ No		**Caseworker**
Authorized Contact #1			
First Name		**Surname**	
Street	**House #**	**Location**	
Primary Phone #	**Back up Phone #**		**Is person working?** ☐ Yes ☐ No
Contact Signature:		**Date:**	
Authorized Contact #1			
First Name		**Surname**	
Street	**House #**	**Location**	
Phone # 1	**Back up Phone #**		**Is person working?** ☐ Yes ☐ No
Contact Signature:		**Date:**	

Consent to Treatment Initiation

Authorized Contacts Consent Contact #1

I (first name) _____ (surname) _____ understand that I have been designated as an authorized person to fetch treatment on behalf of (client name) _____ at Ubuntu Education Fund. I consent to this responsibility and acknowledge that I am required to bring the following items in order to receive the treatment:

1. Identity document or passport
2. Ubuntu passport of the person whose treatment I am fetching

Lastly I acknowledge that the information given above about my home address and contact numbers is correct.

Signed: Date:

Ubuntu Witness: Date:

Consent to Treatment Initiation

Authorized Contacts Consent Contact #2

I (first name) _____ (surname) _____ understand that I have been designated as an authorized person to fetch treatment on behalf of (client name) _____ at Ubuntu Education Fund. I consent to this responsibility and acknowledge that I am required to bring the following items in order to receive the treatment:

1. Identity document or passport
2. Ubuntu passport of the person whose treatment I am fetching

Lastly I acknowledge that the information given above about my home address and contact numbers is correct.

Signed: Date:

Ubuntu Witness: Date: