AdvertQuote

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Quotation Advert

Opening Date:	2021-09-09
Closing Date:	2021-09-16
Closing Time:	11:00

INSTITUTION DETAILS

Institution Name:	Zululand district office
Province:	KwaZulu-Natal
Department or Entity:	Department of Health
Division or section:	Central Supply Chain Management
Place where goods / services is required	Zululand Health District Office
Date Submitted	2021-09-07

ITEM CATEGORY AND DETAILS

Quotation Number:	ZNQ: ZUL-44/21/22
Item Category:	Goods
Item Description:	PRINTING OF PEADS CLINICAL CHARTS X 6 000 PRINTING OF ADULT CLINICAL CHARTS X 12 000
Quantity (if supplies)	

COMPULSORY BRIEFING SESSION / SITE VISIT

Select Type:	Not Applicable
Date :	
Time:	
Venue:	

QUOTES CAN BE COLLECTED FROM:	DEPARTMENTAL WEBSITE /ZULULAND HEALTH DISTRICT OFFICE SCM
QUOTES SHOULD BE DELIVERED TO:	ZULULAND DISTRICT OFFICE TENDER/thabisile.madela@kznhealth.gov.za

ENQUIRIES REGARDING THE ADVERT MAY BE DIRECTED TO:

Name:	S.T.MHLUNGU
Email:	thabisile.madela@kznhealth.gov.za
Contact Number:	0358740681
Finance Manager Name:	SIBIYA B.C
Finance Manager Signature:	

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: ZULULAND HEALTH DISTRICT OFFICE

DATE ADVERTISED: 09/09/2021 CLOSING DATE: 16/09/2021 CLOSING TIME: 11:00

FACSIMILE NUMBER: 086 533 9906 E-MAIL ADDRESS: thabisile.madela@kznhealth.gov.za

PHYSICAL ADDRESS: KING DINUZULU HIGHWAY ,LA ADMIN BLOCK GROUND FLOOR ZONE 6 ULUNDI

ZNQ NUMBER: ZUL - 44/21/22

DESCRIPTION: PRINTING OF PEADS AND ADULT CLINICAL CHARTS

CONTRACT PERIOD..... (*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)*

KING DINUZULU HIGHWAY ,LA ADMIN BLOCK GROUND FLOOR ZONE 6 ULUNDI

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: ZULU-44/21/22

DESCRIPTION: PRINTING OF PEADS AND ADULT CLINICAL CHARTS

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	c
01	6000 UNITS	PRINTING OF PEADS CLINICAL CHARTS				
02	12000 UNITS	PRINTING OF ADULT CLINICAL CHARTS				
		SAMPLE CAN BE VIEWED AT THE				
		NEAREST HEALTH FACILITY				
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: S.T.MHLUNGU Tel: 0358740681

E-Mail Address: thabisile.madela@kznhealth.gov

Enquiries regarding technical information may be directed to:

Contact Person: S.B.NZUNGANA Tel: 0358740727

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 Act, 1999 (Act No. 1 of 1999);
b) any municipality or municipal entity;
c) provincial legislature;
d) national Assembly or the national Council of provinces; or
e) Parliament.

[2]"Shareholder" means a person who owns shares in the company and is actively involved in the management of the enterprise or business and exercises control over the enterprise.

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 until the closing time of the quotation/bids. Where, however, a quotation is received open, it shall be sealed. If it is received without a quotation/bid number on the envelope, it shall be opened, the quotation number ascertained, the envelope sealed and the quotation number written on the envelope.
5.4. A specific box is provided for the receipt of quotations, and no quotation found in any other box or elsewhere subsequent to the closing 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 N/A 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

The supplier shall indemnify the **KZN Department of Health** (hear after known as the purchaser) against all third-party claims of infringement of patent, trademark, or industrial design rights arising from use of the goods or any part thereof by the purchaser.

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.

SBD 6.1

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.

---

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 terms of section 9 (1) of the Broad-Based Black Economic Empowerment Act;

(j) **"rand value"** means the total estimated value of a contract in Rand, calculated at the time of bid invitation, and includes all applicable taxes;

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		
Black people who are military veterans		
OR		
Any EME		
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..... ....

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

GENERAL QUOTATIONS

EVALUATION CRITERIA FOR QUOTATIONS ABOVE R30 000

ZNQ: ZUL - 44/21/22

DESCRIPTION: Printing of peads and adult clinical charts .

All offers received shall be evaluated on the following:

1. **Specifications:**

   Only offers that meet the specification and Special Terms and Conditions in all aspects as stipulated in the bid document shall be considered.
   Offers better than specification are considered to be compliant with the specification.

2. **Correctness of information and other imperative areas to be considered:**

   a) All information required in the bid document must be accurate and duly completed including all the appropriate signatures.

   b) None compliance with any requirements from this document and terms and conditions attached may result to elimination from further evaluation process.

   c) The institution is under no obligation to accept the lowest or any quotation.

   d) The price quoted must include VAT and remain firm for the contract period.

   e) The bidder must ensure the correctness and validity of quote.

   f) Registration on Central Suppliers Database.

   g) Previous service rendered (Quality, Duration and record of offers declined)

   h) Database of tender defaulters

   i) Late quotations will not be considered.

   j) All pages of the tender document must be initialed or signed.

3. **Compulsory administrative compliance requirements that must be submitted with the bid**

a) The bidder must submit certified copy of a registration certificate with CIPC.

b) Valid Original Tax Clearance.

c) Certified Copy of the B-BBEE Certificate.

d) Central Suppliers Database number.

e) Bargaining Council Contract Cleaning Services Industry (BCCCI) Certificate.

Where certified copies are requested, bidders must not submit copies of certified copies. Original certification should not be older than three (3) months. Failure to comply with this requirement shall invalidate the bid submitted.

4. **Preferential Point System:**

The 80/20 Preference Point System will be applicable to this bid and the points will be allocated as follows:

PRICE	80
B-BBEE STATUS LEVEL OF CONTRIBUTION	20
Total points for Price and B-BBEE	100

6. **Contract duration or Delivery period**

The required goods and services are anticipated to be delivered within a period of **14 days** unless unforeseen circumstances may arise and reported timeously.
It is imperative to complete the delivery period field on the quotation form. All quotations returned with blank field on delivery period will be disqualified.

Note: For purposes of comparison and in order to ensure a meaningful evaluation, bidders must submit detailed information in substantiation of compliance to the evaluation criteria mentioned. Should the space provided not be adequate, bidders are kindly requested to add extra pages.

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Paediatric and Adolescent (Birth - 15yrs) Stationery

Patient Name: _____

Folder No: _____

- ☐ Current PRE-ART
- ☐ Current ART
- ☐ Transfer Out
- ☐ Lost to Follow Up
- ☐ Deceased

Process Litho: Tel. 031 569 1020

LONGITUDINAL RECORD

Complete each time there is a new stage defining illness, any serious event, TB, new CD4 or viral load, regimen change, or hospitalisation.
Use "⏲" to record duration on ART in months at time of event (if applicable).

Date	⏲	Stage	Weight	Viral load		CD4		Stage defining illness, regimen change, hospitalisation details, etc.
dd / mm / yy	months	I,II,III,IV	##.#	Abs.	Log	Abs	%	description

Referral clinic:				Current ART clinic:	
Presents from:	☐ TB clinic / this PHC	☐ PMTCT / other PHC	☐ other ART clinic / GP	☐ In-patient / Other:	

PATIENT DETAILS

Date: dd / mm / yy

First name		Facility Phone #	
Surname		Nursery School / Creche	
DOB	/ / Gender: M / F	Primary School	
ID / Passport #	y y m m d d		
Current Age	years months	High School	
Nationality			

Details of Primary Care giver *This is the address where the patient is currently staying*	Name Relation Contact number Address	Details of Secondary Care giver / contact person *This contact person is intended to help trace the patient if need be, thus it can be a aunt, teacher, community minister, neighbour, work etc*	Name Relation Contact number Address

Allergies ☐ None ☐ Unknown ☐ Yes, specify

LONG-TERM RECORD

Use this section to maintain an ongoing summary of your patient's health. If another clinician sees this patient for the first time five years from now, s/he should be able to ascertain the major features of the clinical course from this page. Tick / mark with a X in the appropriate box if it applies / is applicable

HIV Infection Confirmation and Patient Eligibility for ART

Child < 18 months	PCR test positive	Date PCR tested positive: dd / mm / yy	Confirmatory PCR Test	Date of Confirmatory PCR: dd / mm / yy	Confirmed HIV Infection		
Child > 18 months	Screening Rapid Test positive	Confirmatory Rapid Test positive	Date tested positive: dd / mm / yy	ART eligibity criteria met	Yes	No	
CD4 count	%	WHO Staging	Stage 1 / Stage 2 / Stage 3 / Stage 4	ART eligibility criteria used	Age	CD4	WHO stage

Mode of Transmission	Vertical Transmission (from mother)	ARVs prior to ART start date?	None	HAART
	Sexual Transmission		NVP	Number of weeks
	Other:		Patient PMTCT	Other:

ART Initiation Details

ARV start date	/ /	ART Regime started	

Disclosure

Disclosure Status	Not disclosed	Partially disclosed	Not disclosed	Details:

Immunization Status *(pls update until 12 years)*

Up to date? *(at first visit)* ☐ Yes ☐ No ☐ Unknown ☐ No RTHC

Details:

Birth	BCG	OPV0			
6 weeks	DTaP-IPV/Hib 1	OPV1	HepB1	PCV1	RV1
10 weeks	DTaP-IPV/Hib 2		HepB2		
14 weeks	DTaP-IPV/Hib 3		HepB3	PCV2	RV2
9 months			Measles1	PCV3	Vit A & Deworm
18 months	DTaP-IPV/Hib 4		Measles2		Vit A & Deworm
6 years	Td				Vit A & Deworm
12 years	Td				Vit A & Deworm

Other (specify at what age):

Past medical history *Record all significant medical events that occurred before this patient record was started*

ART Transfer-In / Transfer-out

Note: Patient can only be considered transferred in if this record can be completed in full from the date of the original start. If there is prior treatment with incomplete treatment history, the patient should be considered a new patient with prior HAART exposure

ARV start date (at other clinic)	dd / mm / yy	Referral Clinic (Where ART was initiated)	Clinic name	Transfer-IN date (ART patients only)	dd / mm / yy
ART Regime		Months on ART		Months on Regime	
ARV start date	dd / mm / yy	Tranferring to Clinic (where patient will receive ART in future)	Clinic name	Transfer-OUT date (ART patients only)	dd / mm / yy
ART Regime		Months on ART		Months on Regime	

FIRST VISIT CLINICAL ASSESSMENT

Use this section during your patient's first encounter with HIV / ART services

Tuberculosis Screen

TB Screening

Does the patient have: ☐ close TB contact ☐ Cough > 2 weeks ☐ Fever > 7 days ☐ Not growing well

TB Features

Possible TB if 2 or more present: ☐ Cough > 2 weeks ☐ Weightloss ☐ Fatigue / reduced playfulness ☐ Fever > 14 days

TB Classification

- ☐ TB Exposure *If yes:* TB contact has: ☐ TB ☐ MDR ☐ XDR
- ☐ No Classification required (No TB, TB exposure or possible TB)
- ☐ Possible TB (If 2 or more TB features present)
- ☐ Current TB *If yes:* Type of TB: ☐ PTB ☐ ETB ☐ Both
  Date commenced treatment: dd / mm / yyyy
  Treatment: ☐ XDR ☐ MDR ☐ Regime 3A ☐ Regime 3B ☐ Other

Previous TB History

Ever had TB before: ☐ No ☐ Yes *If yes:*

Year	ETB / PTB / Both	Outcome

TB Testing

Tests	Date	Result	Clinical Indication of TB			
☐ Gene Xpert	dd / mm / yy		☐ Pos	☐ Neg		
☐ Smear	dd / mm / yy		Yes	No		
☐ Culture / sensitivity	dd / mm / yy					
☐ X-ray	dd / mm / yy					
☐ TST	dd / mm / yy	mm	☐ Pos	☐ Neg		

TB Screening Outcome

☐ TB Treatment ☐ IPT ☐ Nil

Notes:

WHO clinical staging for Infants and Children

Stage every 6 months or more frequently if patient is unstable

	Clinical Features	Date
WHO Stage 1	Asymptomatic	
	Persistent generalised lymphadenopathy	
WHO Stage 2	Unexplained persistent hepatosplenomegaly	
	Papular pruritic eruptions	
	Extensive wart virus infection	
	Extensive molluscum contagiosum	
	Recurrent oral ulcerations	
	Unexplained persistent parotid enlargement	
	Herpes zoster	
	Recurrent / chronic URTI (o.m., sinusitis, otorrhoea)	
	Fungal nail infections	
WHO Stage 3 Moderate disease	Unexplained moderate malnutrition (weight-for-age, weight-for-height or height-for-age z score ≥ -3 and < -2) not responding to standard therapy	
	Unexplained persistent diarrhoea (≥14 days)	
	Unexplained persistent fever (>37.5°C, > 1 month)	
	Persistent oral candidiasis (after 6 weeks of life)	
	Oral hairy leukoplakia	
	Acute necrotizing ulcerative gingivitis / periodontitis	
	Lymph node TB	
	Pulmonary TB	
	Severe recurrent bacterial pneumonia	
	Symptomatic lymphoid interstitial pneumonitis (LIP)	
	Chronic HIV-associated lung disease incl. bronchiectasis	
	Unexplained anaemia (< 8g/dl), neutropaenia (<0.5x109/L3) or chronic thrombocytopaenia (<50 x 109/L3)	

	Clinical Features	Date
	Weight-for-age, weight-for-height or height-for-age z score <-3 with or without presence of symmetrical oedema	
WHO Stage 4 Severe disease (AIDS)	Pneumocystic pneumonia	
	Recurrent severe bacterial infections (excl. pneumonia)	
	Extrapulmonary TB	
	Chronic herpes simplex infection (oral or skin for > 1 month, or visceral at any site)	
	Kaposis sarcoma	
	Oesophageal candidiasis (or candida of trachea, bronchi or lungs)	
	CNS toxoplasmosis outside neonatal period	
	HIV encephalopathy	
	CMV infection (retinitis or another organ outside neonatal period)	
	Extrapulmonary cryptococcosis including meningitis	
	Any disseminated endemic mycosis	
	Chronic cryptosporidiosis (with diarrhoea) / Isosporiasis	
	Disseminated non-tuberculous mycobacteria infection	
	Cerebral or B-cell non-Hodgkin lymphoma	
	Progressive multifocal leukoencephalopthy (PML)	
	HIV associated cardiomyopathy or nephropathy	
	Acquired HIV-associated rectovaginal fistula	
	Other:	

Reproductive Health

☐ Not applicable ☐ Reproductive assessment done

Is the patient currently pregant: ☐ No ☐ Yes *If yes*, what trimester: ☐ 1 ☐ 2 ☐ 3 Grav: Para:

Pap smear result: Date: d d / m m / y y

Contraception: ☐ Condoms ☐ Injection ☐ Pill ☐ None ☐ Other, specify:

Signs and Symptoms of STI today? ☐ Yes ☐ No ☐ Not applicable

- ☐ Urethral discharge
- ☐ Vaginal discharge
- ☐ Genital ulcers
- ☐ Genital warts
- ☐ Lower abdominal pain
- ☐ Other, specify:

RPR (date)	Result	Treatment Completed
d d / m m / y y		

Clinical Plan

- ☐ Start ART (see Section 6 for initiation details)
- ☐ Enrol in Pre-ART

Notes:

Print name: Signature: Date: dd / mm / yy

PSYCHOSOCIAL READINESS

NB: DON'T DELAY INITIATION FOR SECTIONS 4 AND 5!!!

Use this section to determine if the adolescent/care giver is motivated, has received ARV education and has a degree of social support

Is the biological mother alive ☐ No ☐ Yes Date of Death: dd / mm / yyyy Cause of death:

Maternal Health

(only complete if the biological mother is present to provide information, if biological mother not present complete primary care giver)
Maternal PMTCT refers to PMTCT received while pregnant with the patient

Mother ID number: Y Y M M D D HIV Status: ☐ Positive ☐ Negative ☐ Unknown Clinic:

PMTCT Drugs: ☐ None ☐ Prophylaxis ☐ HAART ARV Details: On HAART ☐ Yes ☐ No

ARV details and history: ARV details: CD4: Date: dd / mm / yy

Date started: dd / mm / yy Clinic: Date Started: dd / mm / yy

TB Treatment: ☐ None ☐ Previous ☐ Present If present, number of months on treatment: Clinic:

Is this mother available and willing to give medication: ☐ Yes ☐ No Has the mother disclosed her status to another adult: ☐ Yes ☐ No

Alternative / Primary Caregiver

(anyone other than the mother that is also primarily responsible for the patients wellbeing)

Relation: Name: HIV Status: ☐ Positive ☐ Negative ☐ Unknown Clinic:

CD4: Date: dd / mm / yy ARV Treatment: ☐ No ☐ Yes Start date: dd / mm / yy Clinic:

TB Treatment: ☐ None ☐ Previous ☐ Present If present, number of months on treatment: Clinic:

Is this caregiver available and willing to give medication: ☐ Yes ☐ No Has the care giver disclosed his / her status to another adult: ☐ Yes ☐ No

Pre-ART Counselling

Counsellors to use this section to record your patients counselling history

Session	Date / s	Individual / group*	Caregiver / adolescent attended?	Comments (e.g. motivation, level of understanding)	Counsellor Name (name and signature)
General HIV education and healthy living					
ARVs					
Adherence planning and demonstration of medicines					
Other					

Sources of support for client: *(specify and tick appropriate)* ☐ Friends ☐ Family ☐ Teacher ☐ Other

Caregiver / adolescent agreed to home visit? Confirm address on front ☐ Yes ☐ No

Name of community health worker:

Caregiver / adolescent attends a support group? ☐ Yes ☐ No

Describe the emotional wellbeing of the client (e.g. is the client withdrawn, moody, anxious, calm, positive, optimistic etc):

☐ Moody ☐ Calm ☐ Withdrawn ☐ Other
☐ Anxious ☐ Positive ☐ Optimistic

Child / Adolescent: What is clients understanding (in their own words) for wanting ARVs?

Notes: Referral: ☐ Counsellor ☐ Social worker ☐ Psychologist ☐ Other, specify:

ASSESSMENT OF PSYCHO-SOCIAL READINESS FOR ART

To be completed by a healthcare worker

Print name: Signature: Date: dd / mm / yy

SOCIAL RECORD

Date: dd / mm / yy

Use this section to assess the need for social assistance *(record the date this social assessment was done)*

Is patient aware of their own HIV status? ☐ No ☐ Yes Details:

If patient is **adolescent**, has patient disclosed HIV status to someone other than caregiver? ☐ No ☐ Yes To Whom:

Is there any drug or alcohol abuse in household, ☐ No ☐ Yes or by the patient? ☐ No ☐ Yes Details:

Other household members: **Please use columns below to list the details of each person living in household, prioritise immediate family**

Name	1)	2)	3)	4)	5)
Relation to patient					
Year Born					
HIV Status ? / + / -					
General Health Status					

Has the caregiver disclosed the patient's status to another adult: ☐ No ☐ Yes If Yes, to Whom:

Will someone other than primary caregiver also administer ART to child? ☐ No ☐ Yes If Yes, name and relation:

Household's source of income? ☐ Employed ☐ Disability grant ☐ Child support grant ☐ Foster grant ☐ Pension ☐ Friends or family ☐ Other

Qualifies for grant? ☐ No ☐ Yes ☐ Child Support Grant ☐ Care Dependency Grant ☐ Other **Receiving grant?** ☐ Yes ☐ No **Application submitted** ☐ Yes ☐ No

CLINICAL ASSESSMENT FOR ART INITIATION

If ARV therapy is indicated for your patient, use this section to help decide whether there are any medical contra-indications to starting

NIMART

Please note this patient should be referred if any yes was marked for the questions

General danger signs present:	☐ Yes	☐ No	Weight < 3kg:	☐ Yes	☐ No	Should ART be nurse initiated:	☐ Yes ☐ No
Other severe classification:	☐ Yes	☐ No	TB:	☐ Yes	☐ No		
Fast breathing:	☐ Yes	☐ No	Other:				

Baseline Laboratory Investigations

Test	Date	Result	Test	Date	Result	Notes
CD4 (abs / %)	/ /		Hb	/ /		
			If Hb < 10g/dL classify and treat for Anaemia			
Viral load (abs / log)	/ /		ALT	/ /		
Other	/ /		Other	/ /		

Clinical factors influencing ARV choice

Patient is less than 3 years	☐ Yes	☐ No	PMTCT and / or NVP experienced	☐ Yes	☐ No	Functioning refrigerator	☐ Yes ☐ No
Weight is less than 10 kilograms	☐ Yes	☐ No	Currently on TB treatment	☐ Yes	☐ No		

ART Plan

ART PLAN AND NOTES:

Signature:

Medication	Dosage	Frequency	Duration	Signature
ARV 1				
ARV 2				
ARV 3				
ARV 4				
ARV 5				

PROBLEM LIST

1.
2.
3.
4.
5.
6.
7.
8.

NB: do not wait for the VL result before starting ART
However you must make sure that the result is checked at a later stage.

ASSESSMENT OF CLINICAL READINESS FOR ART

Print name: Signature: Date: / /

*** Note: Please complete form up to section 7 prior to commencing patient on ART ***

ART READINESS CHECKLIST

Use this area to ensure the review of sections 4 through 6, ensuring completeness, proper planning and readiness of patient and caregiver

Review and update section 5 (above) if it was completed some time before this section

Date: / /	Y	N	Initiation notes (date):
Is patient clinically ready? (section 6)			
Have all clinical factors influencing regimen choice been reviewed? (section 6)			
Has the caregiver/adolescent disclosed to anyone? (section 5)			
Has caregiver/adolescent attended all the required counselling sessions? (see section 4)			
Has the caregiver and patient honoured all the clinic appointments?			

ASSESSMENT OF OVERALL READINESS FOR ARVs

Name:
Signature: Date: dd / mm / yy

ART Start Date: dd / mm / yy

NUTRITIONAL ASSESSMENT

Date: dd / mm / yy

Baseline Nutritional Assessment

Weight (kg):	Height/length *(cms)*:	Head circumference *(cms)*:	MUAC *(cms)*:	BMI:

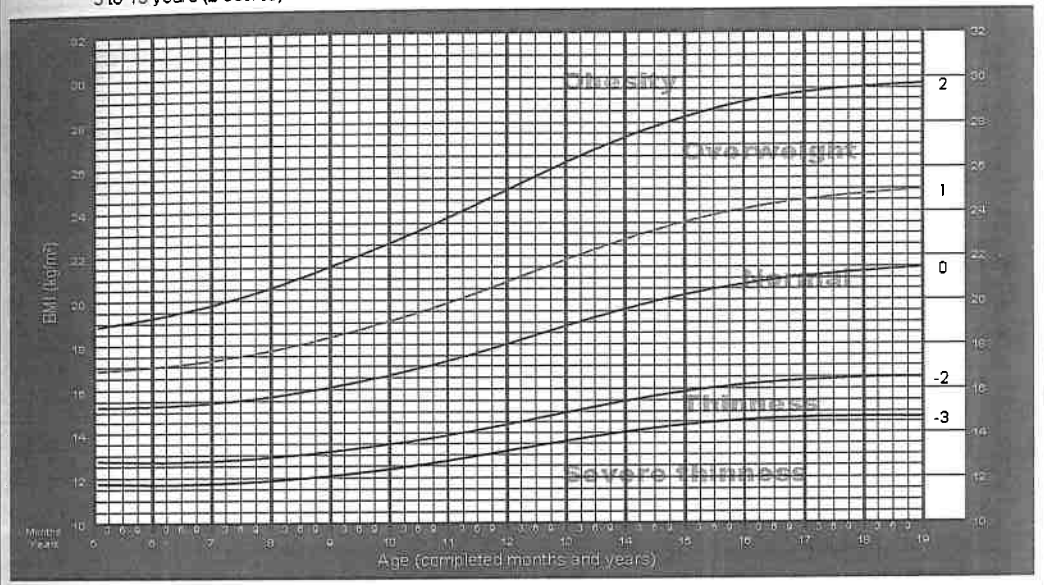
Nutritional assessment and Notes:

Growth Monitoring

BMI-for-age GIRLS

World Health Organization

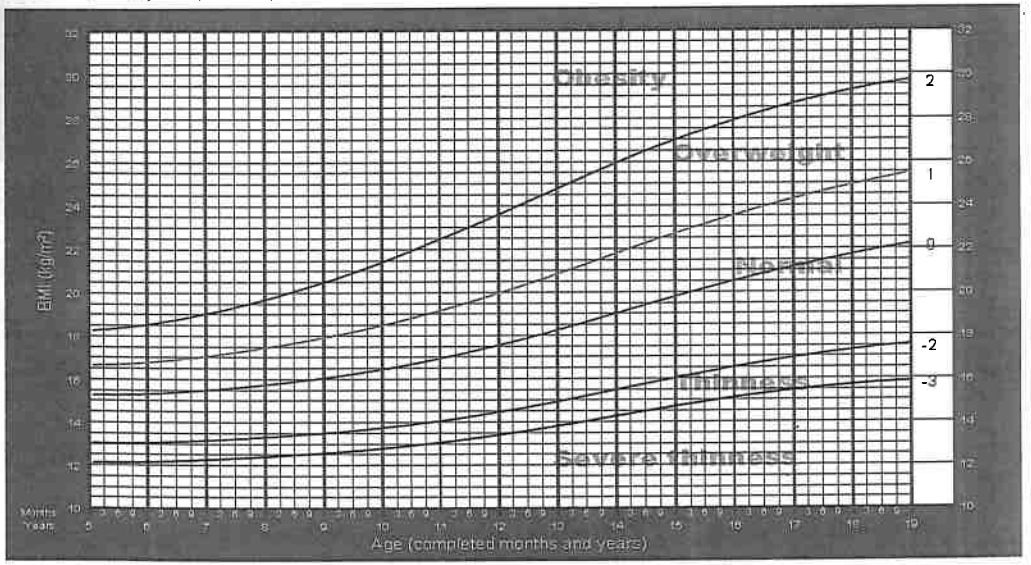
5 to 19 years (z-scores)



BMI-for-age BOYS

World Health Organization

5 to 19 years (z-scores)



Date: dd / mm / yy Arrival Time: hh : mm Next Bloods: dd / mm / yy

General History

Age at current visit:
Months on HAART:
Months on Regime:
Defaulted Treatment: No / Yes If yes, how many months:
Reinitiated Treatment: No / Yes If yes, when: dd / mm / yy
Patient present at the appointment: Yes / No
Pregnant: Yes / No If yes, how many weeks:

Psychosocial Status

Disclosure Status: Disclosed / Partially Disclosed / Not disclosed Details:
Emotional Status: Moody / Withdrawn / Depressed / Positive / Calm / Anxious / Optimistic
Has the patient lost a family member / loved one to death: No / Yes
If yes, refer patient for counselling and / or to the social worker as necessary

Nutritional Assessment

Weight: kg Height: cm Temperature: °C
BMI*: MUAC*: cm Head circum*: cm
* BMI for patients 2-20 years, MUAC for patients 6 months - 5 years, Head Circumference as per RTHC
Nutritional classification and Notes:

Problem List

1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Danger Signs

General Danger Signs
No general danger signs / Danger signs present, specify:
ART Danger Signs
No ART danger signs / Severe skin rash / Difficulty breathing and severe abdominal pain / Yellow eyes / Fever, vomiting, rash (if on Abacavir)

History, Examination and Assessment Notes

Symptoms / Problems

No symptoms and or problems / Fever / Other problems, specify:
Cough / difficult breathing / Ear problem / Diarrhoea / Lethargic

TB Screen

No classification required (no TB) / Possible TB / Current TB / TB exposure
If on treatment, how many months:

Monitor ARV Treatment

Assess and classify for Malnutrition: Growing well / Not growing well / Severe Malnutrition
Assess Development (Birth - 5 years): Developing well / Some delay / Losing milestones
School Attendance: Attending primary / high school / Attending creche / nursery school / Not attending school at all / On holiday
School Progress (5-15 years): Progressing well / Not progressing / Not applicable
Assess Side Effects: Nausea / Sleep disturbances / Abnormal distribution of fat / Tingling/numb/painful hands/feet/legs / Rash / Diarrhoea / Dizziness / Other, specify:
Assess Adherence: Takes all doses / Frequently misses a dose / Occasionally misses a dose / Not taking medication

Investigations

Most recent PREVIOUS results
Date of results: dd / mm / yy
CD4 count: cells/mm³ % ALT:
Viral Load: TG:
HB / WCC / PLT LDL Chol:
Creatinine clearance TB M / C / S:
Notes:

Test should be done according to current policy
Date of current bloods taken: dd / mm / yy
CD4 count: cells/mm³ % ALT:
Viral Load: TG:
HB / WCC / PLT LDL Chol:
Creatinine clearance TB M / C / S:
Other investigation results (including XR):

Sticker 1 Sticker 2

Counselling

Family planning / Adherence / Nutrition / Substance abuse / Side effects / Disclosure / Bereavement / Grief / Other: / Other:
Notes:

Medication

Medication	Dosage	Frequency	Duration	Pill In	Pill Out	Signature	REPEAT 1 dd / mm / yy	REPEAT 2 dd / mm / yy
ARV 1								
ARV 2								
ARV 3								
ARV 4								
Multivitamin								
Cotrimoxazole								

Referrals

Notes:
Immunization / TB / Social worker / Dietician / Counsellor / OPD / PMTCT / Other: / Psychologist / Other:

Follow Up

Clinician Sign Clinician Name Next visit date: dd / mm / yy
Data capturer sign Data capturer Name Data captured: dd / mm / yy
REPEAT 1 Next visit date: dd / mm / yy Clinician Sign Data Capt Sign
REPEAT 2 Next visit date: dd / mm / yy Clinician Sign Data Capt Sign

Date: dd / mm / yy Arrival Time: hh : mm Next Bloods: dd / mm / yy
General History
Psychosocial Status
Nutritional Assessment
Problem List
Danger Signs
History, Examination and Assessment Notes
Symptoms / Problems
TB Screen
Monitor ARV Treatment
Investigations
Counselling
Medication
Referrals
Follow Up

TRACING RECORD

Use this section to record any tracing of this patient

Today's Date	Date of last appointment patient attended	Describe actions taken to trace the patient	Outcome of Tracing: Lost to Follow up	Outcome of Tracing: Defaulted / reinitiated etc	Name and Signature	Date patient returned to facility
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy
dd / mm / yy	dd / mm / yy					dd / mm / yy

GENERAL NOTES

Use this section for additional notes

LONGITUDINAL RECORD

Complete each time there is a new stage defining illness, any serious event, TB, new CD4 or viral load, regimen change, or hospitalisation.
Use "⊙" to record duration on ART in months at time of event (if applicable).

Date	⊙	Stage	Weight	Viral load		CD4		Stage defining illness, regimen change, hospitalisation details, etc.
dd / mm / yy	months	I,II,III,IV	##.#	Abs.	Log	Abs	%	description

LONGITUDINAL RECORD

Complete each time there is a new stage defining illness, any serious event, TB, new CD4 or viral load, regimen change, or hospitalisation.
Use "◷" to record duration on ART in months at time of event (if applicable).

Date	◷	Stage	Weight	Viral load		CD4		Stage defining illness, regimen change, hospitalisation details, etc.
dd / mm / yy	months	I,II,III,IV	##.#	Abs.	Log	Abs	%	description

Place lab results and other free notes here

DISCLAIMER & ACKNOWLEDGEMENT

The reproduction of this toolkit is made possible by the support of the American people through the U.S. Agency for International Development (USAID) under the Cooperative Agreement No. AID-674-A-12-00019. The contents are the sole responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.

USAID
FROM THE AMERICAN PEOPLE

MatCH
Maternal, Adolescent and Child Health Systems
School of Public Health
Faculty of Health Sciences
University of the Witwatersrand

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

HAST UNIT
230 Prince Alfred Street
Pietermaritzburg
3200
Tel. No.: (033) 341-4000
www.kznhealth.gov.za

Process Litho: Tel. 031 569 1020

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

FILE NUMBER

PATIENT NAME

HAST

ADULT CLINICAL CHART

Referral clinic:	Current Clinic:

1. PATIENT DETAILS

Date: / /

First name		Folder #	
Surname		Phone #	
DOB	/ / Sex: M / F	Address	
ID Number			

Next of kin: name, address and contact no.	

2. LONG-TERM RECORD

Use this section to maintain an ongoing summary of your patient's health. If another clinician sees this patient for the first time five years from now, s/he should be able to ascertain the major features of the clinical course from this page.

Year HIV Diagnosed		ART start date at this or transferring clinic	/ /	Transfer-in Date (ART only)	/ /

Note: Patient can only be considered transferred in if this record can be completed in full from the date of the original start.
If there is prior treatment with incomplete treatment history, the patient should be considered a new patient with prior HAART exposure

HAART prior to above start date?	NONE / PMTCT / HAART / PEP	Details

Past medical history — *Record here significant medical events that occurred before this patient record was started*

Longitudinal Record — *Complete each time there is a new stage defining illness, new CD4 or viral load, regimen change or a hospitalisation*
Record here the date and duration on ART in months "◷" (if applicable), CD4, viral load, stage, pap, regimen changes and hospitalisations

Date	◷	Stage	Weight	Viral load	CD4	Stage defining illness, regimen change, hospitalisation details, pap, etc.
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						
/ /						

Patient Summary

3. CLINICAL ASSESSMENT: FIRST VISIT AT THIS CLINIC

Use this section during your patient's first encounter with HIV / ART services to help decide whether they need HIV or ART care

Presents from: TB clinic / PMTCT / VCT / GP / other ART clinic / primary care clinic / in-patient / correctional / work / other

WHO CLINICAL STAGING:

If your patient has, **OR HAS EVER HAD**, any of the illnesses below, and none in stage 4, and a CD4 count > 350, they need HIV care			If your patient has, **OR HAS EVER HAD**, any of the illnesses below, **or** their CD4 count is < 350, they need HAART		
Clinical Features		**Date**	**Clinical Features**		**Date**
WHO Stage 1	Persistent generalised lymphadenopathy		WHO Stage 4 (AIDS) Severe disease	Herpes simplex virus lesions > 1 month	
	Other:			Oesophageal candidiasis	
WHO Stage 2	Weights loss <10% body weight			Pneumocystis jiroveci (formerly PCP)	
	Minor mucocutaneous conditions			Kaposi's sarcoma	
	Recurrent URTI			HIV wasting syndrome	
	Uncomplicated herpes zoster			HIV encephalopathy	
	Other:			Recurrent pneumonia	
WHO Stage 3 Moderate disease	Weight loss >10% body weight			Cytomegalovirus	
	Diarrhoea > 1 month			Isosporiasis / Cryptosporidiosis	
	Oral candidiasis			Bedridden > 50% / day for most of last month	
	Severe bacterial infections including Pneumonia			Cryptococcal meningitis	
	Oral hairy leukoplakia			Cervical cancer	
	Prolonged fever			Lymphoma	
	Bedridden < 50% / day for most of last month			Extra-pulmonary TB	
	Pulmonary TB (current or in the last year) *			Other	
	Other:			CD4 result	

REPRODUCTIVE HEALTH

Pregnant Y N	Trimester 1 2 3	Grav	Para	Pap smear result:	Date:
Contraception: none / condom / injection / pill / other	Date last used:				

Signs and symptoms of STI today?	1) Urethral discharge / dysuria Y / N	2) Vaginal discharge Y / N	3) Genital ulcers Y / N	4) genital warts Y / N	5) Lower abdominal pain Y / N	RPR (date) + result	Tx completed Y / N

TUBERCULOSIS SCREEN

			Year	EPTB or pulmonary TB	Treatment outcomes
Ever had TB before? Y N		If YES			

Current TB Y N	Pulmonary or extra-pulmonary	Date commenced treatment	
TB symptoms today	1) Cough > 2 wks Y / N	2) Weight loss Y / N	3) Fever Y / N
	4) Night sweats Y / N	5) Haemoptysis Y / N	6) Fatigue Y / N
Smear date / Result		Culture / sensitivity date / Result	Clinical indication of TB Y / N

NUTRITIONAL SCREEN (Note: If BMI is less than 18.5 must refer to dietician and nutritional programme)

Date of assessment: / /	A. Weight: *(kg)*	B. Height *(meters)*	C. BMI = Weight (A) / Height (B) X Height (B)	

HISTORY AND EXAMINATION:

Temperature:

Heart Rate:

Blood Pressure:

Respiratory Rate:

PLAN:

CD4 > 350 AND stage 1 - 3 ☐

CD4 < 350 ☐

Cotrimoxazole

Fluconazole

Other:

Screened for IPT: Y N Date:	Qualifies for IPT Y N Date:	Started IPT Y N Date:
Screened for cotrimoxazole: Y N Date:	Already on cotrimoxazole Y N Date:	Qualifies / started Y N Date:
Screened for other / fluconazole Y N Date:	Already on other / fluconazole Y N Date:	Qualifies / started Y N Date:

Print name: Signature: Date: / /

4. CLINICAL EVALUATIONS FOR HAART OR TO RE-START HAART

If HAART is indicated for your patient, use this section to help decide whether there are any medical contra-indications to starting

PRIOR HAART HISTORY

If your patient has ever had previous HAART, detail the period when taken, treatment changes and the reasons they stopped treatment:

BASELINE SAFETY BLOODS

Test	Date	Result	Other tests	Date	Result	Notes
ALT			Creatinine Clearance			
Haemoglobin						
CD4						

TB WORK-UP

Symptoms suspicious of TB? Y N — **If YES:** Perform TB work-up, record results in visit summary sheet

NUTRITIONAL ASSESSMENT

Symptoms Nausea / Vomiting / Diarrhoea / Severe loss of weight / Difficulty swallowing — **Baseline BMI**

CLINICAL NOTES

CLINICAL FACTORS INFLUENCING REGIMEN CHOICE

1. On TB treatment? Y / N	5. Has had more than 1 month of HAART? (excluding PMTCT or PEP) Y / N	**PLAN:**
2. Pregnant? Y / N	6. BMI > 27.5 Y / N	ARV 1
3. Has severe peripheral neuropathy? Y / N	7. Other Y / N	ARV 2
4. Has a history of psychiatric illness? Y / N	8. Other Y / N	ARV 3
		Cotrimoxazole
		Fluconazole
		IPT

COMMENCING HAART

Psychosocial readiness (see section 7) Y / N	Clinically ready Y / N
Regimen factors (clinical factors influencing choice) Y / N	Regimen Y / N

ASSESSMENT OF OVERALL READINESS FOR HAART

Signature: Date: / /

#		Date: / /	/ /	/ /	/ /
		N / D :	N / D :	N / D :	N / D :
History and examination	Weight				
	Temp / Height				
	Months on ART				
	Months on regimen				
	Notes				
	STI screen FP / Condoms				
	TB status	Assessed / No signs / TB suspect / TB Rx			
	Months on TB Rx				
Investigations	TB M / C / S				
	CD4 (CD4%)				
	Viral Load				
	ALT				
	HB / WCC / PLT				
	Other investigation results (incl. XR)				
Assessment	HIV conditions / OIs, TB & other conditions	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
	Adverse event / grade				
	Adverse event / grade				
	Stage chances				
Plan and treatment	Notes				
	Adherence & Counselling	IN ▼ / OUT ▼ / PH	IN ▼ / OUT ▼ / PH	IN ▼ / OUT ▼ / PH	IN ▼ / OUT ▼ / PH
Drugs and dosages	ARV 1				
	ARV 2				
	ARV 3				
	Contrimoxazole				
	INH				
	Fluconazole				
	Referred				
	Date of next visit	/ /	/ /	/ /	/ /
	Signed (initialed)	Nurse/Doctor			
	Pharmacist				
	Date	/ /	/ /	/ /	/ /
	Signed	Data Capturer			

5. SOCIAL ASSISTANCE

Use this section to assess the need for social assistance (record the date this social assessment was made) / /

Lives in what sort of dwelling? (please circle)	informal dwelling / formal house / hostel / other (specify)	Number of rooms	Refrigerator: Y N
Number of adults in household	Current partner in household Y N	Is current partner husband/wife? Y N	Is current partner aware of HIV status Y N

Age and HIV status of children

Own children	Age							Other children in household					
HIV status	- / +							Age					
In household	Y / N							HIV status - / +					

Has patient disclosed HIV status Y N To Whom:

Source of income? (circle) employed / grant / pension / friends or family

Qualifies for grant Y N DG Child Other: Receiving grant Y N Application Submitted Y N

Current drug use	Current alcohol use	CAGE questionnaire			Cage Score
Y N	Y N	Have you ever felt you should cut down on your drinking	Y N	Have people annoyed you by criticising your drinking Y N	
		Have you ever felt guilty or bad about your drinking	Y N	Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover Y N	

Referral Clinic: Appointment Date:

6. PRE-ART COUNSELLING

Use this section to record your patients counselling history

Session	Date/s	Counsellor / group	Tx buddy attended?	Comments (e.g. motivation, level of understanding)
General HIV Education and Healthy Living				
Antiretroviral Therapy				
Adherence Planning				
Other				

Name and contact 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 HAART?

7. PSYCHO-SOCIAL READINESS

Date: / /

If it has been decided HAART can safely be started (section 4) use this section to help decide if your patient is psychologically and socially prepared for HAART.

Review and update section 5 (above) if it was completed some time before this section

IMPORTANT NOTE: The checks below are **ONLY** a prompt for the health care worker to check that the patient is:
a) self motivated, **b)** has received HIV / ART education and **c)** has a degree of social support

	Y	N		Y	N
Have they attended all the required counselling sessions? (see above)			Do they have a treatment buddy		
Have they disclosed to anyone?			Have they been attending the clinic regularly?		

If the answer to all of the above questions is YES then the patient is ready to commence HAART

...es of Details

Use this to make any extra notes regarding change of paitent's Physical address or Contact telephone number

9. Notes

Use this section to make any extra notes regarding the patient

9. Notes (continued)

Use this section to make any extra notes regarding the patient

Notes (continued)

Use this section to make any extra notes regarding the patient

9. Notes (continued)

Use this section to make any extra notes regarding the patient

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

END-USER SPECIFICATION FORM

Quote Number:

Item Description: Paeds clinical charts and Adults clinical charts

Department/Section: Programs- HAST **Purpose of Item:** Testing and screening of clients

1. Pre-qualification criteria if any:

1.1. **Is the item required to have a regulatory body certification (e.g. , etc.)? Yes**
Regulatory Body / certification required if Yes: _

1.2. **Is a compulsory site inspection / briefing session required? NO**
if Yes, specify: Date..... Place .....

1.3. **Is local production and content part of the quote? Yes**
if Yes, specify: 100%

1.4. **Provisions of section 4(1)(a) of the PPPFA Regulations,2017 if applicable? Yes / No**
if Yes, specify:

1.5. **Liability Cover insurance? Yes / No**
if Yes, specify:

2. What is the specification of the required item?

List specifications to be advertised		Comment
1.	Paeds Clinical Charts x 6 000 copies as per attached sample	
2.	Adults Clinical Charts x 12 000 copies as per attached sample	
3.		
4.		
5.		
6.		
7.		
8.		
9.		

3. Does a sample need to be submitted? / No(select option 3.1 or 3.2)

3.1. Deadline for submission if Yes: Date ___/___/___ Time___:___ Place

or

3.2. Specify that samples must be made available when requested in writing. Yes ☐ or No ☐

4. Penalties to be noted by the suppliers:

4.1. 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.

5. What is the evaluation criteria / special terms and conditions to be advertised?

List evaluation criteria / special terms and conditions to be advertised (if applicable)		
1.	Pre-qualification criteria	As per attached on quotation
2.	Preference points	

Name of End-user (in full)		Name of SCM Rep (in full)	KHANYILE M [illegible]
Designation / Rank (in full)		Designation/ Rank (in full)	SUPPLY CHAIN CLERK
Signature		Signature	
Date		Date	28/07/2021