Adult Initial Clinical Evaluation

1. Facility Name: _____ **2. LGA:** _____ **3. State:** _____

4. Visit Date: / / 20 **5. Date HIV Confirmed** / / 20

6. Patient Name _____ **7. Hospital(Unit) No** _____

8. Unique ID State _____ Facility No _____ Serial enrollment No **9. Sex:** Male ☐ Female ☐

10. ANC No: _____ **11. Date of Birth (DD/MM/YYYY)** / / 20 **11b. Age** _____ yrs

12. Presenting complaint: _____

Medical History

13. Symptom review:

	Duration		Duration		Duration
☐ Fever/chills		☐ Rash		☐ Shortness of breath	
☐ Nausea/vomiting		☐ Itching		☐ New visual imparity	
☐ Night sweats		☐ Chronic diarrhea		☐ Pain/difficulty when swallowing	
☐ Recent weight loss		☐ Genital discharge		☐ Numbness/tingling	
☐ Cough		☐ Genital itching		☐ Pain (other site)	
☐ Headache		☐ Genital sores			

14. Patient assessed for TB Yes ☐ No ☐

15. Additional comments _____

16. Past medical history: _____

17. Relevant family history: _____

18. Hospitalization: _____

19. Drug allergies: _____

20a.Currently pregnant Yes ☐ No ☐ Uncertain ☐ **20b. Last menstrual period** / /

20c. Gestational age _____ wks **20d. Expected date of delivery** / /

20e. Currently breastfeeding Yes ☐ No ☐ Uncertain ☐

21. Previous ARV exposure Yes ☐ No ☐

Earlier ARV but not a transfer in ☐ PMTCT only ☐ Has never received ARVs ☐

21a. Name of Facility: _____

21b. Duration of Care from / / to / /

22. Current medications None ☐ ART ☐ CTX ☐ Anti-TB drugs ☐ Other (specify) _____

(Care-giver should probe) If Yes,

23. Patient has disclosed status to: No one ☐ Family member ☐ Friend ☐ Spouse ☐ Spiritual leader ☐

Others (specify): _____

24. HIV status can be discussed with : _____

(record reported person, if any)

25. Past or current ARV side effects None ☐

Signif. nausea/vomit	☐	Insomnia / bad dreams	☐	Steven Johnson syndrome	☐	Hyperglycemia	☐
Headache	☐	Confusion/dizzy	☐	Itching	☐	Kidney problems	☐
Diarrhea	☐	Tingling of extremities	☐	Anemia	☐	Liver problems	☐
Pain in abdomen or muscle	☐	Rash	☐	Weakness/fatigue	☐	Others (specify)	☐
Jaundice	☐	Pancreatitis	☐	Fat accumulation or loss	☐	_____	

Patient Name _____ **Hospital No** _____

Unique ID _____ (State) _____ (Facility No) _____ (Serial enrollment No)

26. Physical exam *(note: NSF= no significant findings)*

Temp: . °C | **BP** / mm/Hg | **Pulse** b/min | **Wt** kg | **Ht** m

General appearance ☐ NSF
- Pallor ☐
- Febrile ☐
- Dehydrated ☐
- Jaundice ☐
- Peripheral edema ☐
- Other (specify)_____

Skin ☐ NSF
- Pruritic paplar dermatitis ☐
- Abscesses ☐
- Herpes zoster ☐
- Kaposi's lesions ☐
- Suborrheic dermatitis ☐
- Fungal infections ☐
- Other (specify) _____

Head/Eye/ENT ☐ NSF
- Icterus ☐
- Thrush ☐
- Oral KS ☐
- Abnormal fundoscopy
- Other (specify)_____

Breasts ☐ NSF
- Lumps, masses ☐
- Discharge ☐
- Other (specify)_____

Cardiovascular ☐ NSF
- Abnormal heart rate ☐
- Auscultation finding ☐
- Other (specify) ☐

Genitalia NSF ☐
- Genital discharge ☐
- Genital ulcer/other lesion ☐
- Inguinal node enlargement ☐
- Other (specify)_____

Respiratory ☐ NSF
- Rate _____ breaths/min
- Labored breathing ☐
- Cyanosis ☐
- Wheezing ☐
- Intercostal (sub) recession ☐
- Auscultation findings ☐
- Other (specify)_____

Gastrointestinal ☐ NSF
- Distention ☐
- Hepatomegaly ☐
- Spenomegaly ☐
- Tenderness ☐
- Other (specify) ☐

Neurological ☐ NSF
- Orientation to TPP ☐
- Speech slurs ☐
- Neck stiffness ☐
- Blindness 1/2 eyes ☐
- Hemiplegia/paresis ☐
- Numbness of extremities ☐
- Other (specify)_____

Mental status ☐ NSF
- Slow mentation ☐
- Memory loss ☐
- Mood swings ☐
- Depression ☐
- Anxiety ☐
- Suicidal ideation ☐
- Other (specify)_____

Additional and detailed findings: _____

27. Assessment Asymptomatic ☐ Symptomatic ☐ AIDS defining illness ☐ Opportunistic infection ☐

28a. WHO staging criteria (History of any of the following)

Stage 1
- Asymptomatic ☐
- Persistent generalized lymphadenopathy ☐
- Performance scale: 1 asymptomatic, normal activity ☐

Stage 2
- Weight loss <10% of body weight ☐
- Minor Mucocutaneous Manifestations ☐
- Herpes Zoster (within last 5 years) ☐
- Recurrent Upper Respiratory Tract Infections ☐
- Performance scale: 2 symptomatic, normal activity ☐

Stage 3
- Weight loss >10% of body weight ☐
- Unexplained Chronic Diarrhea (>1 month) ☐
- Unexplained Prolonged Fever ☐
- Oral Candidiasis ☐
- Oral Hairy Leukoplakia ☐
- TB, Pulmonary (within previous year) ☐
- Severe Bacterial Infections ☐
- Performance scale: 3 bedridden <50% of day in last month ☐

28b. WHO Stage ☐

Stage 4
- HIV Wasting syndrome ☐
- PCP ☐
- Toxoplasmosis, CNS ☐
- Cryptosporidiosis with Diarrhea (>1 month) ☐
- Cryptococcosis, Extrapulmonary ☐
- Cytomegalovirus disease ☐
- Herpes Simplex (mucotaneous >1 month) ☐
- Progressive Multifocal Leukoencephalopathy ☐
- Mycosis, disseminated ☐
- Candidiasis ☐
- Atypical Mycobacteriosis, disseminated ☐
- Salmonella Septicemia, Non-typhoid ☐
- TB, Extrapulmonary ☐
- Lymphoma ☐
- Kaposi's Sarcoma ☐
- HIV encephalopathy ☐
- Performance scale: 4 bedridden >50% of the day in last month ☐

29. Plan (specify orders on requisition)

Lab evaluation ☐	_____	OI therapy ☐	_____
Investigate for tuberculosis ☐	_____	Admission ☐	_____
OI Prophylaxis ☐	_____	Symptomatic treatment/pain control (specify) ☐	_____
Adherence counseling ☐	_____	Other referrals (specify) ☐	_____

30. Enrol in: General medical follow-up ☐ ARV therapy ☐ Pending lab results ☐

31. Plan for ARV therapy

- Ongoing monitoring –ARV Tx post-poned for clinical reasons ☐
- Start new treatment ☐
- Change treatment ☐
- Restart treatment ☐
- Stop treatment ☐

32a. Regimen

1st Line		2nd Line		3rd-Line/Salvage Regimens	
1a = TDF+3TC (or FTC) +EFV	☐	2a = AZT + 3TC + LPV/r	☐	3a = DRV/r +DTG ± 1-2 NRTIs	☐
1b = TDF+3TC (or FTC) +DTG	☐	2b = AZT+ 3TC + ATV/r	☐	3b = DRV/r +2NRTIs ± NNRTI	☐
1c = AZT+3TC +NVP (or EFV)	☐	2c = TDF +3TC + ATV/r	☐		
1d =TDF+3TC(or FTC)+EFV 400	☐	2d = TDF +3TC + LPV/r	☐		
1e = ABC +3TC+EFV	☐	2e = AZT + TDF + 3TC + ATV/r	☐		
1f = TDF +3TC (or FTC) + NVP	☐	2f = AZT + TDF + 3TC + LPV/r	☐		

32 b. Drugs in regimen _____ / _____ / _____

33. Next appointment _____ / _____ / 20_____ (dd/mm/yyyy)

Clinician's name (Print) _____ **Signature** _____

Care/ART CARD Number ___ | **FACILITY NAME** _____ | **1. Hospital number** _____

INITIAL VISIT

2. Unique ID: ☐☐ ☐☐☐ ☐☐☐☐ ☐☐☐☐ **3. Date enrolled in HIV care:** _____

4. Surname: _____ **Other Names:** _____ **5. Address:** _____

5a. Occupation: _____ **5b. Marital Status** ☐ **5c. Educational Status** ☐ _____

5d. Telephone no. _____ **5e. Next of kin:** _____ **5f. Relationship** _____

5g. Telephone no. (Next of kin) _____

6. Sex: M ☐ F ☐ **7. Age** _____(Yrs/Months) **8. DoB** _____ (dd/mm/yyyy) **9. Mother's Unique ID (if infant)** ☐☐ ☐☐☐ ☐☐☐☐ ☐☐☐☐

10. Care Entry Point ☐ _____ **11. Date of Confirmed HIV test** _____ (dd/mm/yyyy) **12. Mode of HIV Test : [HIV-Ab] [PCR]** *(circle as appropriate)*

13. Where _____ **14. Prior ART** _____

15. Date Transferred in _____ **16. Facility transfered from** _____

10. Care Entry Point:

OPD - 1
In patients-2
HTS- 3
TB DOTS-4
STI Clinic -5
ANC/PMTCT-6
Transfer-in -7
Outreaches - 8

13. Prior ART:

1 = Transfer in with records
2 = Transfer in without records
3 = PMTCT Only

5b Marital Status
1. Single
2. Married
3. Divorced
4. Seperated
5. Cohabiting
6. Widow/er

5c Educational Status
1. No education
2. Primary Education
3. Secondary Education
4. Tertiary Education
5. Others (Specify)

ART COMMENCEMENT

17. Clinical Stage at start of ART _____ **18. CD4 at start of ART** _____

19. Date Initial Adherence Counseling Completed _____ **20. Date ART started** _____ **21. First ART Regimen** _____

22. Weight _____(kg) **23. Height/length** _____(m/cm) **24. BMI/MUAC** _____ **25. Functional Status** ☐

26. Pregnant ☐ **Breastfeeding** ☐

25. Function code
1. Working
2. Ambulant
3. Bed ridden

SUBSTITUTIONS/SWITCHES

Substitution within ☐ **1st Line** ☐ **2nd Line** ☐ **3rd Line**

27. Date of New Regimen _____ **28. Why** ☐☐ **29. New Regimen** _____

30. Date of New Regimen _____ **31. Why** ☐☐ **32. New Regimen** _____

Switch to ☐ **2nd Line** ☐ **3rd Line**

33. Date New Regimen _____ **34. Why** ☐☐ **35. New Regimen** _____

36. Date New Regimen _____ **37. Why** ☐☐ **38. New Regimen** _____

28, 31, 34 & 37. Reasons for Regimen Substitutions/Switches
1. Toxicity/side effects
2. Pregnancy
3. Risk of pregnancy
4. Due to new TB
5. New drug available
6. Drug out of stock
7. Clinical treament failure
8. Immunologic failure
9. Virologic failure

39. Why STOP Codes:
1 Toxicity/side effects
2 Pregnancy
3 Treatment failure
4 Poor adherence
5 Illness, hospitalization
6 Drugs out of stock
7 Patient lacks finances
8 Other patient decision
9 Planned Rx interruption
10 Other

DISCONTINUATIONS & INTERRUPTIONS

39. ART Interruptions

Stopped (S) /Default (D) [circle as appropriate]		Date	Why	Date of restart if placed back on medication
S	D			
S	D			
S	D			
S	D			
S	D			
S	D			

40. Date patient transferred-out: _____ **41. Facility referred to** _____

42. Date patient died: _____ **43. Source of death information** _____

44. Cause of Death: **HIV related:** **Yes** ☐ **No** ☐ **Don't know** ☐

45. History of drug allergies: _____

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E1	E2	E3	E4	E5	E6	E7	E8	E9	E10	E11	E12	E13	E14	E15	E16	E17	E18	E19	E20	E21	E22		E23	E24	E25	E26
													ARV DRUGS		COTRIMOXAZOLE		INH				Viral Load Tick if ordered, a. Enter result when available b. Indication for Viral Results					
Visit Date: Tick if scheduled	Duration (in Months) on ART	Weight (kg)	Height / Length (cm)	BMI/ MUAC *(insert code)*	Blood Pressure (mmHg) Adults Only	Pregnancy/ Breastfeeding Status	Family Planning (write code)	Functional status *(write code)*	WHO Clinical Stage	TB Status (write code)	Other OIs/ Other Problems	Noted Side Effects	Regimen	Adherence	Dose	Adherence	Dose	Adherence	Other Drugs Prescribed	CD4 Tick if ordered. Enter result when available	E22a	E22b	Other Tests Done	Consult Hospitalise Refer Link	Next Appointment Date	Signature
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Codes E7
Pregnancy/ Breasfeeding Status
1. **P** = Pregnant (enter EDD)
2. **BF** = Breastfeeding

E9. Function code
1. Working
2. Ambulant
3. Bed ridden

Codes E8
Family planning status.
FP = On Family planning
No FP = Not on family planning
In brackets write type of FP used
1 = Condoms
2 = Oral contraceptive pills
3 = Inject able/implantable hormones (e.g. Depo-provera)
4 = Diaphragm/cervical cap
5 = Intrauterine device
6 = Vasectomy/tubal ligation/hysterectomy
7 = Others

Codes E11
TB status (assess at each visit):
1. **No signs** = no signs or symptoms of TB
2. **Presumptive TB** = Patient with signs and symptoms of TB and referred for evaluation
3. **IPT** = Currently on INH prophylaxis
4. **Confirmed TB** = Patient has active TB
   4a. Confirmed with GeneXpert
   4b. Confirmed with Sputum AFB Microscopy

Nutritional status (BMI/MUAC) scores:

	Adults	Pregnant women	Children
1.	<18.5kg/m²	<23cm	≤12.5cm
2.	(18.5kg/m² - 24.9kg/m²)	≥23cm	>12.5cm
3.	≥25.0kg/m²	NA	NA

Scores:
1 = Underweight
2 = Well nourished
3 = Overweight/Obese

Codes E12
New OI or other problems:
1.Herpes Zoster
2.Pneumonia
3. Dementia/Encephalitis
4.Thrush oral/vaginal
5. Fever
6. Cough

Codes E13
Noted Side Effects
1.Nausea/vomiting
2. Headache
3.Insomnia/bad dreams
4 Fatigue/weakness
5.PV bleeding/discharge
6.Rash
7.FAT changes
8.Anemia
9 Drainage of liquor
10.Stevens Johnson syndrome
11.Hyperglycemia

E14. Regimen Codes

Adult 1st-Line Regimens:
1a = TDF+3TC (or FTC) +EFV
1b = TDF+3TC (or FTC) +DTG
1c = AZT+3TC +NVP (or EFV)
1d = TDF+3TC(or FTC) + EFV 400
1e = ABC +3TC+EFV
1f = TDF +3TC (or FTC) + NVP

Adult 2nd-line regimens:
2a = AZT + 3TC + LPV/r
2b = AZT+ 3TC + ATV/r
2c = TDF +3TC + ATV/r
2d = TDF +3TC + LPV/r
2e = AZT + TDF + 3TC+ ATV/r
2f = AZT + TDF + 3TC+ LPV/r

Adult 3rd-Line Regimens
3a = DRV/r +DTG ± 1-2 NRTIs
3b = DRV/r +2NRTIs ± NNRTI

Paediatric 1st-Line Regimens
4a = TDF +3TC (or FTC) + EFV
4b = TDF+ 3TC (or FTC) + DTG
4c = TDF+ 3TC (or FTC) + EFV400
4d = AZT + 3TC+ NVP (or EFV)
4e = ABC + 3TC (or FTC) + DTG
4f = ABC+ 3TC (FTC) + EFV400
4g = TDF + 3TC (or FTC) + NVP
4h = ABC + 3TC (or FTC) + NVP
4i = ABC + 3TC+ EFV
4j = ABC + 3TC + LPV/r
4k = AZT + 3TC + LPV/r
4l = TDF+ 3TC (or FTC) + EFV
4m= AZT + 3TC + RAL

Paediatric 2nd-Line Regimens
5a = AZT + 3TC + LPV/r
5b = AZT+ 3TC + ATV/r
5c = TDF +-3TC + ATV/r
5d = TDF + 3TC + LPV/r
5e = AZT or ABC + 3TC + RAL
5f = AZT +3TC + LPV/r
5g = ABC +3TC + LPV/r

Paediatric 3rd-Line Regimens
6a = DRV/r +DTG ± 1-2 NRTIs
6b = DRV/r +2NRTIs ± NNRTI
6c = RAL (or DTG) + 2 NRTIs
6d = DRV/r +2NRTIs
6e = DRV/r + RAL (or DTG) ± 1-2 NRTIs

Codes E15, E17, E19
Level of Adherence
Estimate adherence for twice daily ART using the following table: | **Estimate adherence for once daily ART using the following table:**

% Missed doses per month			
G (Good)	≥ 95%	≤ 3 doses	1 dose
F (Fair)	85-94%	4-8 doses	1 -3 doses

Codes E15, E17, E19
Why Poor /Fair adherence:
1 Forgot
2 Fell asleep/slept through dose
3 Change in routine/away from home
4 Busy/working/at school
5 Got pregnant
6 Patient moved
7 Ran out of medications
8 Drug stock-out
9 Not able to pay
10 Felt well
11 Felt sick/bad
12 Felt overwhelmed/depressed
13 Did not understand how to take medication
14 Did not want others to know
15 Too many pills
16 Did not want to take meds
17 Afraid of/affected by drug side effects
18.Other (specify)

E22 B
Targeted = T
Routine = B

Codes E23
Other Tests
1. HB/PCV
2. WBC + Diff
3. ALT
4. AST
5. Creatinine
6. Lipid Profile
7. HBsAg/HCV
8 VDRL
9. Urinalysis
10. Sputum AFB
11. Chest Xray
12. Other (specify)

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ART Adherence Preparation

Services	Date	Date	Date
ART -- educate on essentials			
Why complete adherence needed			
Explain dose, when to take, what to do when one forgets dose			
What can occur; how to manage side effects			
Adherence plan (schedule, aides, explain diary, preparation for travel)			
Treatment supporter preparation			
Name, address, telephone contacts of treatment supporter			
Indicate when ready for ART (date/result)			

Care and Support/Positive Health Dignity and Prevention Services

Services (Indicate 'X' if service provide on date)	Dates															Comment
Adherence counseling																
Basic HIV education and transmission including nutrition																
Prevention counselling: abstinence, safer sex, household precautions																
Disclosure, partner testing and counseling, family situation																
Condom provision																
STI screening, diagnosis and referral for management																
Provision/referral for RH/FP services																
Alcohol & other substance use risk reduction counseling																
Symptom management and palliative care at home																
Positive living counselling																
Support group enrollment, community support, clinic contacts																

Mother - Baby Pair

1. ANC Number: _____ 2. Date of Enrollment into PMTCT (dd/mm/yyyy): _____ 3. Time of Diagnosis: Previously in Care/Treatment ☐ ANC ☐ Labour ☐ ≤ 72 hrs Postpartum ☐

GA _____ Gravida _____ > 72 hrs Postpartum ☐

4. Date of Delivery (dd/mm/yyy): _____ 5. Mode of Delivery: Vaginal ☐ Elective CS ☐ Emergency CS ☐ Others ☐

Date of birth* (dd/mm/yy)	Child's hospital number	Birth weight (kg)	Sex (M/F)	Prophylaxis initiation		CTX initiation	
				Date of initiation (dd/mm/yy)	Age at initiation (weeks)	Date of initiation (dd/mm/yy)	Age at initiation (weeks)

*Use rows below for multiple births

Visit Date (dd/mm/yyyy) Tick if scheduled	Age (weeks)	Weight (kg)	Length (cm)	Infant Feeding at Present (Enter code)	Infant ARV Prophylaxis Status (Yes or No)	Mother's Current ART Status (Enter code)	On Cotrimoxazole Yes/ No	Date of PCR Sample Collection (dd/mm/yyyy)	Date PCR Sample Sent (dd/mm/yyyy)	Date PCR Result Received (dd/mm/yyyy)	PCR Result	Rapid Test Result at 18 Months	Reason for Repeat PCR (Enter code)	Result of Repeat PCR	Child Outcome at 18 Months (Enter code)	Referred to HIV Care (Enter infant's ART Unique ID)	Next Appointment Date (dd/mm/yy)	Signature
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Feeding Practice Code

1 = Exclusive Breast Feeding (EBF)

2 = Commercial Infant Formula

3 = Mixed Feeding (MF)

Child Outcome code

HIV Positive
1= Linked to ART
2=Not Linked to ART

HIV Negative
3=HIV Negative, Not breastfeeding

HIV Status Unknown
4=Still breastfeeding
5=Dead
6= Lost to follow-up
7=Transfered Out

Reason for PCR Code

1 = Infant with Signs and Symptoms of HIV

2 = Follow-Up for Breastfed Child

3 = Previous Indeterminate Test

Mother's ART Status

1 = On ART

2 = Not on ART

Pharmacy Order Form

○ ART ○ Non-ART ○ Occup PEP ○ Non-Occup PEP ○ HIV-Exposed Infant ○ PrEP | ○ Initial Visit ○ Follow-Up Visit

Visit Date (dd/mm/yyyy): / /20

Patient Name: Surname | Other Name(s) **Age:** years | months **Sex:** ○ Male ○ Female

State: _____ **LGA:** _____ **Facility Name:** _____

Unique ID: _____ **Hospital (Unit) No.** _____

Pharmacy Registration No. _____ **Weight:** _____ Kg **Height:** _____ m

Pregnant ○ Yes ○ No **Refill** ○ Yes ○ No ○ **Substitution** ○ **Switch**

1. ARV Medications	Strength	Frequency	Duration	Qty Prescribed	Qty Dispensed
Adult ART					
Tenofovir/Lamivudine/Efavirenz	○ 300/300/600mg	○ OD			
Tenofovir/Lamivudine/Dolutegravir	○ 300/300/50mg	○ OD			
Tenofovir/Lamivudine/Efavirenz	○ 300/300/400mg	○ OD			
Lamivudine/Zidovudine/Nevirapine	○ 150/300/200mg	○ BD			
Tenofovir/Lamivudine	○ 300/300mg	○ OD			
Lamivudine/Zidovudine	○ 300/150mg	○ BD			
Abacavir/Lamivudine	○ 600/300mg	○ OD			
Efavirenz	○ 600mg	○ OD			
Zidovudine	○ 300mg	○ BD			
Atazanavir/Ritonavir	○ 300/100mg	○ OD			
Lopinavir/Ritonavir	○ 200/50mg	○ 2 BD			
Darunavir	○ 600mg	○ _____ BD			
Ritonavir	○ 100mg	○ _____ BD			
Darunavir/Ritonavir	○ 400/50mg	○ BD			
Dolutegravir	○ 50mg	○ OD/BD			
_____	○ _____	○ _____			
	○	○			
Pediatric ART (Please refer to dosing wheel)					
Lamivudine/Zidovudine/Nevirapine	○ 30/60/50mg	○ _____ BD			
Abacavir/Lamivudine	○ 60/30mg	○ _____ OD/BD			
Lamivudine/Zidovudine	○ 60/30mg	○ _____ BD			
Efavirenz	○ 200mg	○ _____ OD			
Nevirapine	○ 50mg/5ml	○ _____ BD			
Abacavir	○ 60mg	○ _____ OD/BD			
Lopinavir/Ritonavir	○ 100/25mg	○ _____ BD			
Lopinavir/Ritonavir	○ 80/20mg/ml	○ _____ BD			
Lopinavir/Ritonavir	○ 40/10mg	○ _____ BD			
Raltegravir	○ 25mg	○ _____ BD			
Zidovudine	○ 10mg/ml	○ _____ BD			
_____	○ _____	○ _____			
2. Drugs for OI Prophylaxis/Treatment	○ ○	○			
Co-trimoxazole	○ 120 mg ○ 960 mg	○ _____ OD			
Fluconazole	○ _____	○ _____ OD			
Isoniazid	○ _____	○ _____ OD			
Nystatin	○ _____	○ _____ QDS			
3. Anti-TB Drugs	○	○			
RHZE/RH	○ Kit	○ _____ OD			
Rifabutin	○ 150 mg	○ _____ 3ce/week			
Others	_____				
	_____				
	_____				
4. Drugs for other OIs or non-HIV related conditions					
	_____				
	_____				
	_____				

_____ / /20 _____ _____

Ordered by (Print Physician's Name) *Signature & Date* *Dispensed by (Print Pharmacist's Name)* *Signature & Date*

_____ / /20 _____ _____

Counseled by (Print Adh.Counselor's Name) *Signature & Date* *Picked up by (Print Name)* *Signature & Date*

Feedback from the Pharmacist in case of any observed medication error (attach additional sheets if needed):

i. Name of the drug(s) _____

ii. Nature of the error(s) _____

iii. Consequence(s) of the error _____

iv. Signature and date _____

Revised November 2017

Laboratory Order and Results Form

Patient's ART status **Pre-ART** ☐ **ART** ☐ **Specimen Collection Date:** _____/_____/_____ (dd/mm/yyyy)

State: _____ **LGA:** _____

Facility Name: _____ **Baseline** ☐ **Repeat** ☐

Patient Name: _____ (Surname) _____ (Other Name(s))

Sex: Male: ☐ Female: ☐ Pregnant (if female): ☐ Breastfeeding: ☐ **Age:** ☐☐ years ☐☐ months

ID: ☐☐☐ - ☐☐☐☐☐☐ (State / Facility No.) ☐☐☐☐☐ (Client No.) **Hospital (Unit) No.** _____

Lab Registration No. _____ **PCR Lab Name:** _____

Tests will only be performed at the laboratory, if all fields above are filled in correctly and signed below by the ordering staff!

ORDERS	RESULTS
☐ CD4+ cell count	☐☐☐☐ cells/mm3
☐ CD4%	☐☐ %
☐ WBC	☐☐☐ x 10^9 c/L
☐ Polymorphs.	☐☐☐☐ /mm^3 ☐☐ %
☐ Lymphocytes	☐☐☐☐ /mm^3 ☐☐ %
☐ Monocytes	☐☐☐☐ /mm^3 ☐☐ %
☐ Eosinophils	☐☐☐☐ /mm^3 ☐☐ %
☐ Basophils	☐☐☐☐ /mm^3 ☐☐ %
☐ PCV/Hb	☐☐☐ % ☐☐☐ g/dl
☐ Platelets	☐☐☐ x 10^9 c/L
☐ HCV antibody	Negative ☐ Positive ☐
☐ HBsAG	Negative ☐ Positive ☐
☐ VDRL	Non-Reactive ☐ Reactive ☐
☐ Creatinine	☐☐☐ µmol/l
☐ ALT/SGPT	☐☐☐☐ U/l
	☐☐☐☐ mmol/L
☐ AST/SGOT	☐☐☐ U/l
☐ Alk. Phosphatase	☐☐☐ U/l
☐ Total Bilirubin	☐☐☐☐ µmol/l
☐ Na^+	☐☐☐ mmol/L
☐ K^+	☐☐☐☐ mmol/l
☐ Fasting Glucose	☐☐☐ mmol/l
☐ Total Cholesterol	☐☐☐ mmol/L
☐ LDL	☐☐☐ mmol/L
☐ HDL	☐☐☐ mmol/L
☐ Urinalysis:	Glucose: ☐ Protein: ☐
☐ Cytology VIA/Pap Smear	

ORDERS	RESULTS
☐ Triglyceride	☐☐☐ mmol/L
☐ Pregnancy	Negative ☐ Positive ☐
☐ Malaria smear	Negative ☐ Positive ☐

Viral Load

PCR Lab Sample No. _____

Sample Type Whole Blood/Plasma ☐ DBS ☐

Collection Date __/__/__ Time: ____ AM PM

Date Received at PCR Lab __/__/__ Time: ____ AM PM

Indication for Viral Load

- ☐ Baseline (6 months after ART initiation)
- ☐ Routine (every 12 months)
- ☐ Clinical failure
- ☐ Immunologic failure
- ☐ Confirmation (3-6 months after intense adherence counselling)
- ☐ Repeat Test

ART Start Date (dd/mm/yyyy): _____

Drug Regimen

1st Line _____ 2nd Line _____

Results

☐ Viral Load ☐☐☐☐☐☐☐ copies/ml

Additional tests (only be performed by laboratory if exact clinical indication specified and signed by clinician!)

Specify exact clinical indication for requested tests:

Name of Clinician:

_____ (Print name) _____ (Signature) _____ (Date (DD/MM/YYY))

Reported by:

_____ (Print name) _____ (Signature) _____ (Date (DD/MM/YYY))

Checked by:

_____ (Print name) _____ (Signature) _____ (Date (DD/MM/YYY))

Paediatric Initial Clinical Evaluation Form

1. Facility Name: _____ 2. LGA _____ 3. State _____

4. Visit Date _____ 5. Date HIV Confirmed ___/___/20___

6. Patient Name _____ 7. Sex: Male ☐ Female ☐

8. Unique ID ☐☐ ☐ ☐☐☐☐☐ ☐☐☐☐☐ (State / Facility No / Serial enrollment No) 9. Hospital(Unit) No ☐☐☐☐☐☐☐☐

10. Date of Birth (DD/MM/YYYY) ____/____/_____ 11. Age ☐☐ *years* If <5 years ☐☐ months

12. Is the mother of child alive? Y ☐ N ☐

If yes: Name _____

Address _____

13. Is the father of child alive? Y ☐ N ☐

If yes: Name _____

Address _____

14. Child's parents/caregivers are:

Married: Y ☐ N ☐

Co-habiting Y ☐ N ☐

Single Y ☐ N ☐

15. How many siblings does the child have? ☐☐

Medical History

16. Symptom review:

	Duration		Duration		Duration
☐ Fever		☐ Ear discharge		☐ Pain on micturition	
☐ Weight loss /failure to gain weight		☐ Oral sores		☐ Genital sores/discharge	
☐ Night sweats		☐ Cough		☐ Numbness/tingling	
☐ Irritability		☐ Difficulty breathing		☐ Convulsion	
☐ Difficulty sleeping		☐ Food refusal		☐ Rash	
☐ Headache		☐ Diarrhoea		☐ Itching	
☐ New Visual Impairment		☐ Nausea/vomiting		☐ Others specify	

17. Patient assessed for TB? Y ☐ N ☐

18. Developmental Assessment: ☐ 1-Appropriate ☐ 2-Delayed ☐ 3-Retarded

19. Immunisation:Complete for Age Y ☐ N ☐ 20. Mode of infant (≤6 months) feeding: EBF ☐ EBMS ☐ Mixed ☐

21. Patient has received previous care for HIV/AIDS: Y ☐ N ☐

21a. Name of Facility: _____

21b. Duration of Care: From __/__/__ to __/__/__

22. Previous ARV exposure other than PMTCT None ☐ Earlier ARV but not a transfer in ☐ Treatment ☐

Months on Treatment ☐ Specify drugs _____

If Yes,(Care-giver should probe)

23. Known drug allergies _____

24. Past medical history (including hospitalisation and surgery) _____

25. Previous ARV exposure through PMTCT Y ☐ N ☐ (Care-giver should probe and specify)

26. Current Medications (Care-giver should probe and specify) None ☐ CTX ☐ ART ☐ Anti-TB drugs ☐

27. Physical exam *(note: NSF= no significant findings)*

Temp °C Pulse ☐ /min Weight ☐ kgs Ht ☐ cm Head circumference ☐ cm Surface Area ☐ cm^3

MUAC cm Normal ☐ Under ☐ Over ☐

General appearance ☐ NSF
- Pale ☐
- Dehydrated ☐
- Jaundiced ☐
- Edematous ☐

Respiratory ☐ NSF
- Rate ____ breaths/min
- Labored breathing ☐
- Inter/subcostal recession ☐
- Cyanosis ☐
- Wheezing ☐
- Auscultation finding ☐
- (specify finding)

Gastrointestinal ☐ NSF
- Hepatomegaly ☐
- Splenomegaly ☐
- Tenderness ☐
- Distention ☐

Skin ☐ NSF
- Pruritic papular dermatitis ☐
- Scabies ☐
- Abscesses ☐
- Kaposi's lesions ☐
- Seborrheic dermatitis ☐
- Herpes zoster ☐
- Fungal infection ☐

Neurological ☐ NSF
- Disoriented in TPP ☐
- Impaired consciousness ☐
- Slurred speech ☐
- Neck stiffness ☐
- Blindness 1 or 2 eyes ☐
- Weakness/paralysis ☐
- Numbness of extremities ☐
- Fisting/spasticity ☐

Cardiovascular ☐ NSF
- Irregular pulse ☐
- Auscultation finding ☐
- (specify finding) ☐

Head/Eye/ENT ☐ NSF
- Thrush ☐
- Oral KS ☐
- Thrush ☐
- Oral KS ☐
- Gingivitis ☐
- Otitis media ☐
- Ear discharge ☐
- Oral ulcer ☐

Glands ☐ NSF
- Parotid swelling ☐
- Lymphadenopathy ☐

Genitalia ☐ NSF
- Genital lesions
- Tanner stage: _____

Mental status ☐ NSF
- Slow mentation ☐
- Memory loss ☐
- Mood swings ☐
- Depression ☐
- Anxiety ☐
- Suicidal ideation ☐

Note: Please review latest lab results

Unique ID State | Facility No | Serial enrollment No **Patient Name :**

28. Additional physical examination findings:

29. Assessment: Asymptomatic ☐ Symptomatic ☐ AIDS defining illness ☐ Opportunistic infections ☐

30. WHO Stage ☐

31. Plan (Order on specific requisition form)

Lab evaluation ☐ _____ OI therapy _____

Screen for tuberculosis ☐ _____ Admission _____

OI Prophylaxis ☐ _____ Symptomatic treatment/pain control (specify) _____

Palliative Care ☐ Psychosocial Support ☐ OVC Care End of Life Care CXR _____

Counseling: ☐ Adherence ☐ HTS ☐ Nutrition ☐ Peer Health Support ☐

Referrals: ☐ Support ☐ PMTCT ☐ Other ☐ _____

32. Enrol in: ☐ General medical follow-up ☐ ARV therapy ☐ Pending lab results ☐

33. ART Plan (if applicable)

Start new treatment (naive patient) ☐ Restart treatment ☐ Continue current treatment ☐

Stop ART (indicate reason code) ☐ Change treatment (indicate reason code) ☐

Codes for Reason for Change/ Stop ART:

1. Can't adhere to schedule 2 Patient refusal/preference 3 Doctor's Instruction 4. Ran out of medicine 5. Drugs not available
7. Toxicity 8. Virologic failure 9. Clinical failure 10. Drug interaction 11. Immunologic failure 12. Other (specify)

34. ART Regimen

	1st Line		2nd Line		3rd Line	
4a	**TDF +3TC (or FTC) + EFV**	☐	**5a AZT + 3TC + LPV/r**	☐	6a **DRV/r +DTG ± 1-2 NRTIs**	☐
4b	**TDF+ 3TC (or FTC) + DTG**	☐	**5b AZT+ 3TC + ATV/r**	☐	6b **DRV/r +2NRTIs ± NNRTI**	☐
4c	**TDF+ 3TC (or FTC) + EFV400**	☐	**5c TDF +-3TC + ATV/r**	☐	6c **RAL (or DTG) + 2 NRTIs**	☐
4d	**AZT + 3TC+ NVP (or EFV)**	☐	**5d TDF + 3TC + LPV/r**	☐	6d **DRV/r +2NRTIs**	☐
4e	**ABC + 3TC (or FTC) +DTG**	☐	**5e AZT or ABC + 3TC + RAL**	☐	6e **DRV/r + RAL (or DTG) ± 1-2 NRTIs**	☐
4f	**ABC+ 3TC (FTC) + EFV400**	☐	**5f AZT +3TC + LPV/r**	☐		
4g	**TDF + 3TC (or FTC) + NVP**	☐	**5g ABC +3TC + LPV/r**	☐		
4h	**ABC + 3TC (or FTC) + NVP**	☐				
4i	**ABC + 3TC+ EFV**	☐				
4j	**ABC + 3TC + LPV/r**	☐				
4k	**AZT + 3TC + LPV/r**	☐				
4l	**TDF + 3TC (or FTC) +EFV**	☐				
4m	**AZT + 3TC + RAL**	☐				

35. Drugs in regimen ___ / / / /

36. Additional comments _____

37. Next appointment 1 week ☐ 2 weeks ☐ 4 weeks ☐ 2 months ☐ 3 months ☐ / / 20 (dd/mm/yyyy)

Clinician's Name (Print): _____ **Signature:** _____

Revised Paediatric Initial Clinical Evaluation -November 2017

Viral Load Order and Results Form

Facility Name: _____

State: _____ **LGA:** _____

Patient Name _____ (Surname) _____ (Other Name(s))

Sex: **Male:** O **Female:** O **Age:** ☐ years if < 2 years ☐☐ months

O **Pregnant**
O **Breastfeeding**

ID ☐☐☐ - ☐☐☐☐☐ ☐☐☐☐☐ (State / Facility No. / Client's Unique No.)

Hospital (Unit) No. _____

Lab Registration No. _____

Sample Type	Whole Blood/Plasma	☐
	DBS	☐

INDICATION FOR VIRAL LOAD TEST:

O **Baseline (6 months after ART Init.)**
O **Routine (every >12months)**
O **Clinical failure**
O **Immunologic Failure**
O **Confirmation (3- 6 months after Intense Adherence Counselling)**
O **Repeat test**

ART Commencement Date _____/_____/_____ (DD/MM/YYYY)

Drugs Regimen

First Line _____

Second Line _____

Ordered by:

_____ *Print name* _____ *Signature* _____ *Date (DD/MM/YYY)*

Tests will only be performed at the laboratory, if all fields above are filled in correctly and signed below by the ordering staff

Collected by:

_____ *Print name* _____ *Signature*

Collection Date _____/_____/_____ (DD/MM/YYYY)

Collection Time _____/_____ AM PM (HR / MIN)

RESULTS

Date Received at PCR Lab _____/_____/_____ (DD/MM/YYYY) **Time** _____/____ AM PM (HR / MIN)

PCR Lab Name _____

PCR Lab Sample No. _____

RESULTS ☐☐☐☐☐☐☐☐ copies/ml

Result Interpretation	Viral suppression <1000 c/ml	Poor-suppression 1000-10000 c/ml	Critical values >10,000c/ml

Comments: _____

_____

Assayed by:

_____ *Print name* _____ *Signature* _____ *Date (DD/MM/YYY)*

Approved by:

_____ *Print name* _____ *Signature* _____ *Date (DD/MM/YYY)*