CLINICAL FOLLOW UP

Date ☐☐ / ☐☐ / ☐☐ (Day / Month / Year)

Patient ID ☐☐☐ - ☐☐☐ - ☐☐☐☐☐ - ☐ (District / Facility / Serial no.)

Facility ID (if different) ________

Clinic code ☐☐

Patient Last Name ________ Patient First Name ________

PRESENTING COMPLAINT

Tick at left if PATIENT mentions any complaints. Note duration, recurrence below.

- ☐ Routine visit
- ☐ No complaint
- ☐ Weight loss
- ☐ Fever
- ☐ Night sweats
- ☐ Vomiting
- ☐ Acute diarrhoea
- ☐ Chronic diarrhoea
- ☐ Sores in mouth
- ☐ Pain/diff swallowing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Numbness/pain/burning in legs/feet
- ☐ Visual problems
- ☐ Headache
- ☐ Rash
- ☐ Swellings/lymph nodes
- ☐ Other
- ☐ Lab results________ mm/yy___/___

Is patient on ART? ◯Yes ◯No

If on ART, how long?____________

Is patient pregnant? ◯Yes ◯No

Estimated date of delivery: ☐☐ / ☐☐ / ☐☐ (Day / Month / Year)

Is pt breastfeeding? ◯Yes ◯No

CURRENT MEDICATIONS

NRTIs
- ☐ Zidovudine (AZT)
- ☐ Stavudine (D4T)
- ☐ Lamivudine (3TC)
- ☐ Abacavir (ABC)
- ☐ Tenofovir (TDF)
- ☐ Didanosine (ddI)
- ☐ Emtricitabine (FTC)

NNRTIs
- ◯ Nevirapine (NVP)
- ◯ Efavirenz (EFV)

PIs
- ◯ Lopinavir/ritonavir (LPV/r)
- ◯ Indinavir (IDV)
- ◯ Nelfinavir (NFV)

Non-ARVs
- ☐ Septrin
- ☐ Fluconazole
- ☐ Anti-malarials
- ☐ TB medication________
- ☐ Traditional medicines and herbs
- ☐ Other________
- ☐ Other________
- ☐ Other________
- ☐ Other________

REVIEW OF SYSTEMS

Within the past month, has the patient experienced any of the following symptoms:

CONSTITUTIONAL		CARDIO-RESPIRATORY			
Fatigue (tired)	◯Yes ◯No	*Productive cough	◯Yes ◯No	Numbness/pain/burning in legs/feet	◯Yes ◯No
*Fever	◯Yes ◯No	*Non-productive cough	◯Yes ◯No	Weakness in limbs	◯Yes ◯No
*Night sweats	◯Yes ◯No	*Hemoptysis	◯Yes ◯No	Seizures	◯Yes ◯No
Appetite loss	◯Yes ◯No	*Difficulty breathing/SOB	◯Yes ◯No	**GENITAL-URINARY**	
*Weight loss	◯Yes ◯No	Dizziness	◯Yes ◯No	Genital ulcers	◯Yes ◯No
GASTROINTESTINAL		Palpitations	◯Yes ◯No	Discharge (urethral/vaginal)	◯Yes ◯No
Acute diarrhoea	◯Yes ◯No	Swelling of legs	◯Yes ◯No	Abnormal bleeding	◯Yes ◯No
Chronic diarrhoea	◯Yes ◯No	**NEUROLOGICAL**		Dysuria	◯Yes ◯No
Nausea and/or vomiting	◯Yes ◯No	Daily headache	◯Yes ◯No	Hematuria	◯Yes ◯No
Oral lesions	◯Yes ◯No	Memory problems	◯Yes ◯No	**OTHER**	
Pain/difficulty swallowing	◯Yes ◯No	Visual problems	◯Yes ◯No	Rash	◯Yes ◯No
Abdominal pain	◯Yes ◯No	Confusion	◯Yes ◯No	Joint pain/swelling	◯Yes ◯No

If yes, describe: ________

** If symptom present, screen for TB using TB Diagnostic Worksheet (where in use)*

PHYSICAL EXAM

Height (cm) ☐☐☐ Weight (kg) ☐☐☐.☐ Wt last visit ☐☐☐.☐

BP ☐☐☐/☐☐☐ Temp. C ☐☐.☐ Heart rate/min ☐☐☐ Resp rate ☐☐

General: ☐ Pallor ☐ Jaundice ☐ Edema

Describe any abnormal findings below:

	Normal	Abnormal	
Skin	◯	◯	________
Eyes	◯	◯	________
Ears, nose	◯	◯	________
Oral	◯	◯	________
Lymph nodes	◯	◯	________
Heart	◯	◯	________
Lungs	◯	◯	________
Abdomen	◯	◯	________
Urogenital	◯	◯	________
Musculoskeletal	◯	◯	________
Neurological	◯	◯	

Clerk initial ________ Staff ID ________ Staff signature ________

ADHERENCE During the last 7 days, how many doses did the patient miss? ________ If > 1 dose missed in 7 days, refer for adherence counselling

WHO STAGING *Assess patient for new or recurring events or status which may indicate changing WHO Stage.*

STAGE 1
- ☐ Asymptomatic HIV infection
- ☐ Persistent gen. lymphadenopathy

STAGE 2
- ☐ Weight loss < 10% body weight
- ☐ Recurrent URIs
- ☐ Herpes zoster
- ☐ Sores/cracks around lips
- ☐ Recurrent mouth ulcers
- ☐ Itching rash
- ☐ Itchy, scaly skin condition
- ☐ Fungal nail infections of fingers

STAGE 3
- ☐ Weight loss > 10% body weight
- ☐ Unexpl. chronic diarrhoea (> 1 mo)
- ☐ Unexpl. persistent fever (> 1 mo)
- ☐ Oral candidiasis
- ☐ Oral hairy leukoplakia
- ☐ Pulmonary TB
- ☐ Severe bacterial infections
- ☐ Severe painful oral ulcers
- ☐ Unexplained anaemia (<8 g/dl)

WHO Stage today ◯ 1 ◯ 2 ◯ 3 ◯ 4

STAGE 4
- ☐ HIV Wasting Syndrome (> 10% wt loss and > 1 mo diarrhea and > 1 mo fever)
- ☐ Pneumocystis pneumonia
- ☐ Recurrent severe or radiological bacterial peumonia
- ☐ Chronic herpes simplex (> 1 mo)
- ☐ Oesophageal candidiasis
- ☐ Extrapulmonary TB
- ☐ Kaposi's sarcoma
- ☐ CNS toxoplasmosis
- ☐ HIV encephalopathy
- ☐ Cryptococcal meningitis
- ☐ Other stage 4:________________

Functional status: ◯ Healthy, able to work ◯ Sick, able to work ◯ Sick, unable to work ◯ Bedridden

ASSESSMENT *Opportunistic infections should be ticked above under WHO Staging. Other conditions noted:*

- ☐ Malaria
- ☐ STI, specify:________________
- ☐ *TB suspect *use TB Diagnostic Worksheet*
- ☐ Anaemia
- ☐ Hypertension
- ☐ Diabetes
- ☐ Acute diarrhoea
- ☐ Chronic diarrhoea
- ☐ Fever
- ☐ Respiratory Tract Infection
- ☐ Urinary Tract infection
- ☐ Other________________

ASSESSMENT OF DRUG-RELATED TOXICITIES AND SIDE EFFECTS

- ☐ None
- ☐ Suspected AZT anaemia
- ☐ Peripheral neuropathy
- ☐ NVP rash
- ☐ EFV CNS symptoms (headache, confusion, bad dreams)
- ☐ Pancreatitis
- ☐ Suspected lactic acidosis
- ☐ PI-related diarrhoea
- ☐ Lipodystrophy/lipoatrophy
- ☐ Hepatotoxicity
- ☐ Suspected immune reconstitution
- ☐ Other________________

ASSESSMENT FOR TREATMENT FAILURE

Last CD4 count result: ________

- ☐ No evidence of treatment failure
- ☐ Occurance/reoccurance of new OI or malignancy signifying HIV disease progression (except TB)
- ☐ Latest CD4 at or below baseline CD4
- ☐ CD4 increase < 50 cells/ul after 6 months of therapy
- ☐ CD4 decrease > 50% from peak level on therapy

Clerk initial ________ Staff ID ________ Staff signature ________

PLAN
- ◯ Assess ART Eligibility
- ◯ Continue ART
- ◯ Stop ART
- ◯ Modify ART regimen: ◯ Change single drug ◯ Change entire regimen
- ◯ Restart ART

REASONS FOR CHANGE/STOP

☐ Pregnancy	☐ TB medication	☐ Anaemia	☐ Pancreatitis
☐ Treatment failure	☐ Patient decision	☐ Neuropathy	☐ Lactic acidosis
☐ Migrant patient	☐ Drug interaction	☐ Rash	☐ Other side effect
☐ Poor adherence	☐ Drug unavailable	☐ Hepatitis	☐ Physician decision

Do at next visit:

ARV PRESCRIPTION. FIRST LINE. Circle OD or BD

- ◯ TDF 300 mg OD + FTC 200 mg OD + NVP 200 mg OD / BD
- ◯ TDF 300 mg OD + FTC 200 mg OD + EFV 600 mg OD
- ◯ AZT 300 mg BD + 3TC 150 mg BD + NVP 200 mg OD / BD
- ◯ AZT 300 mg BD + 3TC 150 mg BD + EFV 600 mg OD
- ◯ D4T 30 mg BD + 3TC 150 mg BD + NVP 200 mg OD / BD
- ◯ D4T 30 mg BD + 3TC 150 mg BD + EFV 600 mg OD
- ◯ ABC 300 mg BD + 3TC 150 mg BD + NVP 200 mg OD / BD
- ◯ ABC 300 mg BD + 3TC 150 mg BD + EFV 600 mg OD

SECOND LINE. Only in consultation with Medical Officer.

- ◯ AZT 300 mg BD + 3TC 150 mg BD + LPV/r 400/100 mg BD
- ◯ AZT 300 mg BD + TDF 300 mg OD + FTC 200 mg OD + LPV/r 400/100 mg BD
- ◯ D4T 30 mg BD + 3TC 150 mg BD + LPV/r 400/100 mg BD
- ◯ ABC 300 mg BD + ddI 250 mg OD + LPV/r 400/100 mg BD
- ◯ TDF 300 mg OD + FTC 200 mg OD + LPV/r 400/100 mg BD
- ◯ Other:__________ + __________ + __________ + __________

PRESCRIPTIONS — Pregnant? ◯ Yes ◯ No

- ☐ Septrin prophylaxis 960mg od x ___days ◯ Start ◯ Cont. ◯ Stop
- ☐ Septrin treatment_______mg_______X_________days
- ☐ Fluconazole maint. 200mg od x ___days ◯ Start ◯ Cont. ◯ Stop
- ☐ Fluconazole treat._______mg_______X_________days
- ☐ Other_______________:______mg______X______days
- ☐ Other_______________:______mg______X______days
- ☐ Fansidar________________________________
- ☐ Coartem________________________________
- ☐ Other___________
- ☐ Multivit 1 tab od x1mo
- ☐ Iron 200mg tds x1mo
- ☐ Folate 5mg od x1mo

TB DRUGS
- ◯ RHZE _____tabs od x_______mo
  - ☐ S _____mg im od x_____mo
- ◯ EH _______tabs od x_______mo
- ◯ RHE ______tabs od x_______mo

If suspect TB, complete TB Diagnostic Worksheet (where in use)

INVESTIGATIONS
- ☐ None
- ☐ CD4 count
- ☐ Hemoglobin/hematocrit
- ☐ Full blood count
- ☐ ALT/AST
- ☐ Creatinine
- ☐ *Sputum AFB
- ☐ Chest X-ray
- ☐ Pregnancy
- ☐ RPR
- ☐ TLC
- ☐ Amylase/lipase
- ☐ Viral load
- ☐ Other__________

REFERRALS
- ☐ None
- ☐ Family planning
- ☐ Nutritional support
- ☐ Inpatient care (this facility)
- ☐ Inpatient care:____________
- ☐ *TB treatment/DOT program
- ☐ Adherence counseling
- ☐ Treatment preparation
- ☐ Psychosocial support
- ☐ Community health worker
- ☐ Other:________________

Next clinical appointment should be in:
◯ 1 wk ◯ 2 wks ◯ 3 wks ◯ 1 mo ◯ 3 mos ◯ 6 mos ◯ Other:________

Date of next visit: ☐☐ / ☐☐ / ☐☐
Day Month Year

Clerk initial ____ Staff ID ____ Staff signature ____