ARV ELIGIBILITY

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

Facility ID (if different) ☐☐

Patient Last Name _____ Patient First Name _____ Clinic code ☐☐

PART A: ARV ELIGIBILITY

Date ☐☐ / ☐☐ / ☐☐
Day / Month / Year

RECENT HISTORY

Highest WHO Stage ☐ WHO date _____ ALT/AST ☐ Creatinine ☐ RPR ☐

CD4 Count ☐ CD4 date _____ Hb/HCT ☐ Pregnancy ☐ Other_____ ☐

EXAMINATION

Weight (kg) ☐☐☐.☐ BP ☐☐☐/☐☐☐ Temp. C ☐☐.☐

Heart rate/min ☐☐☐ Resp rate ☐☐

ASSESSMENT

Patient is currently acutely ill ◯ Yes ◯ No
If yes, fill in Clinical Follow Up Form (if 1st visit note on IHP)

◯ Eligible today by:
- ◯ ARVs taken within past month
- ◯ CD4 < 200
- ◯ CD4 < 350 and WHO Stage 3
- ◯ WHO Stage 4

◯ Not eligible today:
- ◯ CD4 > 200, stage 1/2: review in 3 mos
- ◯ CD4 > 350, stage 3: review in 3 mos
- ◯ CD4 > 350, stage 1/2: review in 6 mos

PLAN

◯ Patient is starting ART today. *Skip to Plan on page 2.*

◯ Patient is not starting ART today. *Tick reason(s) why and indicate date for clinical review below.*

- ☐ Patient starting Septrin prophylaxis today *Review in 2 weeks.*
- ☐ Patient on TB treatment: co-treatment not recommended at this time
- ☐ Patient is pregnant
- ☐ Patient refuses treatment
- ☐ Adherence issues
- ☐ Awaiting blood results
- ☐ Abnormal blood results
- ☐ Other *Specify below.*

Do at next visit:

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

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_____

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

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

☐☐ / ☐☐ / ☐☐
Day / Month / Year

Clerk initial _____ Staff ID _____ Staff signature _____

Patient ID ☐☐☐-☐☐☐-☐☐☐☐☐-☐

PART B: ARV INITIATION

Date ☐☐/☐☐/☐☐ (Day / Month / Year)

RECENT HISTORY

Highest WHO Stage ☐ WHO date _____ ALT/AST ☐ Creatinine ☐ RPR ☐

CD4 Count ☐ CD4 date _____ Hb/HCT ☐ Pregnancy ☐ Other_____ ☐

EXAMINATION

Weight (kg) ☐☐☐.☐ BP ☐☐☐/☐☐☐ Temp. C ☐☐.☐

Heart rate/min ☐☐☐ Resp rate ☐☐

ASSESSMENT

Note any existing conditions that may impact ART regimen selection

Patient is currently acutely ill ◯ Yes ◯ No
If yes, fill in Clinical Follow Up Form

- ☐ Hepatitis, Hep C, other liver disease (consult)
- ☐ Kidney disease, DM (dose adjust where applicable)
- ☐ Neuropathies, DM (avoid D4T when possible)
- ☐ Anaemia, other haematopoietic disease (avoid AZT)
- ☐ TB (avoid NVP)
- ☐ Pregnancy (avoid EFV)
- ☐ Psychiatric problems (avoid EFV)
- ☐ Existing medication use (ensure no interactions)

PLAN

☐ Patient wants to be in home-based care

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

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- ☐ Nutritional support
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- ☐ Treatment preparation
- ☐ Psychosocial support
- ☐ Community health worker
- ☐ Other:_____

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☐☐/☐☐/☐☐ (Day / Month / Year)

Clerk initial _____ Staff ID _____ Staff signature _____