SHORT VISIT

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

Date ☐☐ / ☐☐ / ☐☐
Day / Month / Year

Facility ID (if different) ☐☐☐☐☐

Clinic code ☐☐

Patient Last Name _____ Patient First Name _____

PRESENTING COMPLAINT

☐ Numbness/pain/ burning in legs/feet

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
☐ 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

EXAMINATION

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

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

ASSESSMENT

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

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 300mg 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
☐ 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
☐ Antibiotic_____:_____mg_____X_____days
☐ Antifungal_____:_____mg_____X_____days
☐ Other_____:_____mg_____X_____days
☐ Other_____:_____mg_____X_____days
☐ Other_____
☐ Multivit 1 tab od x1mo
☐ Iron 200mg tds x1mo
☐ Folate 5mg od x1mo

TB DRUGS
◯ INH/RIF/ETH/PZ____tabs od x___mo
☐ Strep _____mg im od x____mo
◯ ETH/INH _____tabs od x____mo
◯ INH/RIF/ETH _____tabs od x____mo

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

INVESTIGATIONS
☐ None
☐ CD4 count
☐ Hb/HCT
☐ 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 _____