KWAZULU NATAL DEPARTMENT OF HEALTH
COMPREHENSIVE CARE PROGRAMME

ADULT PATIENT FORMS TRAINING MANUAL

English Version 1.0
November 2004

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INTRODUCTION TO ADULT PATIENT FORMS

The Adult Patient Forms are in a book format and each form has been printed in duplicate as two-part carbonless copies.

Some forms may appear lengthy - this is because they have been designed in such a way that the majority of the writing is done by simple answer selection and there is as little free-hand writing as possible.

Different forms have been designed for the collection of different types of patient information throughout the Patient Flow.

Each form specifies who is responsible for entering the information in that form (e.g. the admin clerk, the clinician, the counsellor, etc). Please note that this is intended as a general guideline as this could vary depending on the ARV programme operation at your site.

Instructions to follow when completing the Adult Patient Forms:

- Press firmly when writing on a form to ensure that whatever is entered on the top page is transcribed into the bottom page.
- Ensure that you use a page separator to prevent the transfer of marks onto other pages of the form booklet.
- It is preferable to use CAPITAL LETTERS.
- Please write clearly and ensure that your answer selection is well marked.
- Please completely darken (fill-in) the ‘o’ bubbles when selecting your options.
- Please write one letter or digit in each block when blocks are provided.
- If you do not have an answer or relevant response to a question, you should leave the answer block BLANK
- Please do not leave spaces or use dashes when entering contact numbers
  e.g. to enter 0317656398 is correct
  to enter 031-765 6398 is incorrect
- Please put a cross or line through incorrect answers and write the correct answer, as clearly as possible, next to the answer box provided.

OVERVIEW OF FORM FLOW

FORM 1 Adult Patient Registration Form

FORM 2 Adult Baseline Clinical Examination Form

FORM 3 Adult Patient Counselling Form

FORM 4 Adult Baseline Laboratory Results Form

FORM 5 Adult Initiation / Change of Treatment Form

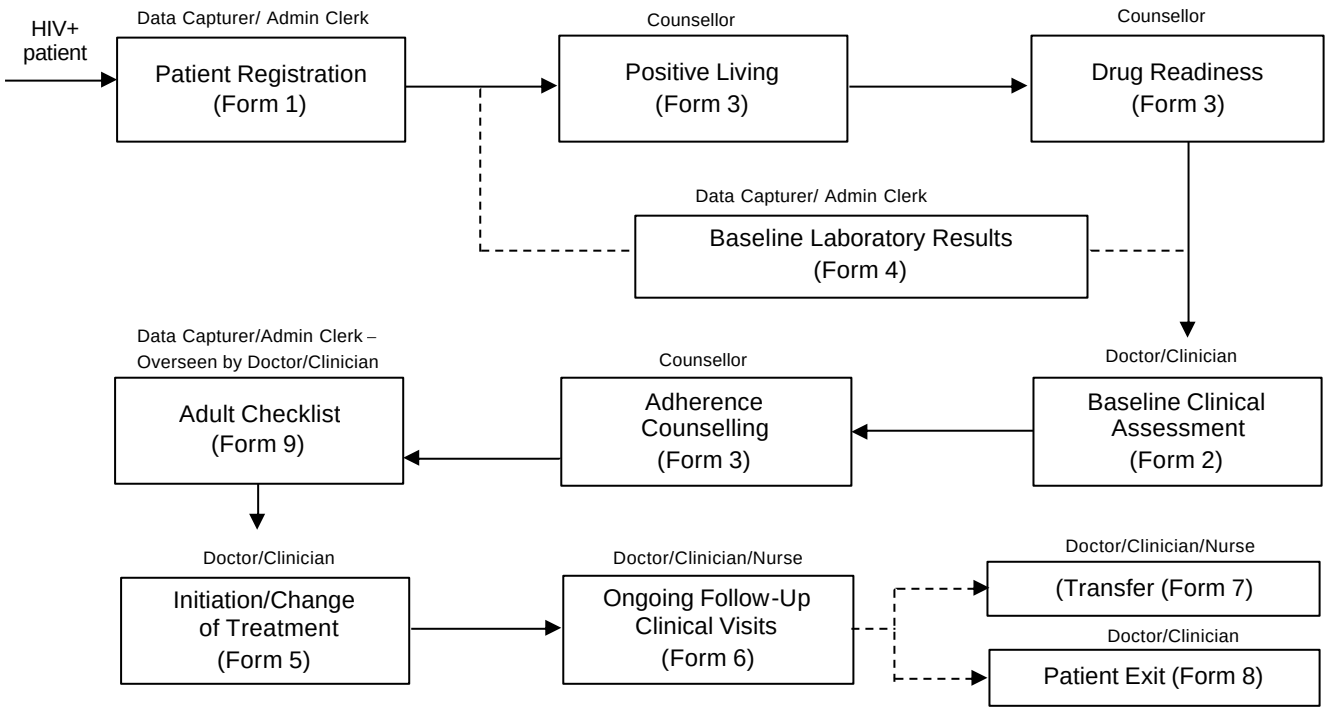
FORM 6 Adult Patient Follow-Up Form

FORM 7 Adult Patient Transfer Form

FORM 8 Adult Patient Exit Form

FORM 9 Adult Checklist Form

Adult Visit Summary Form

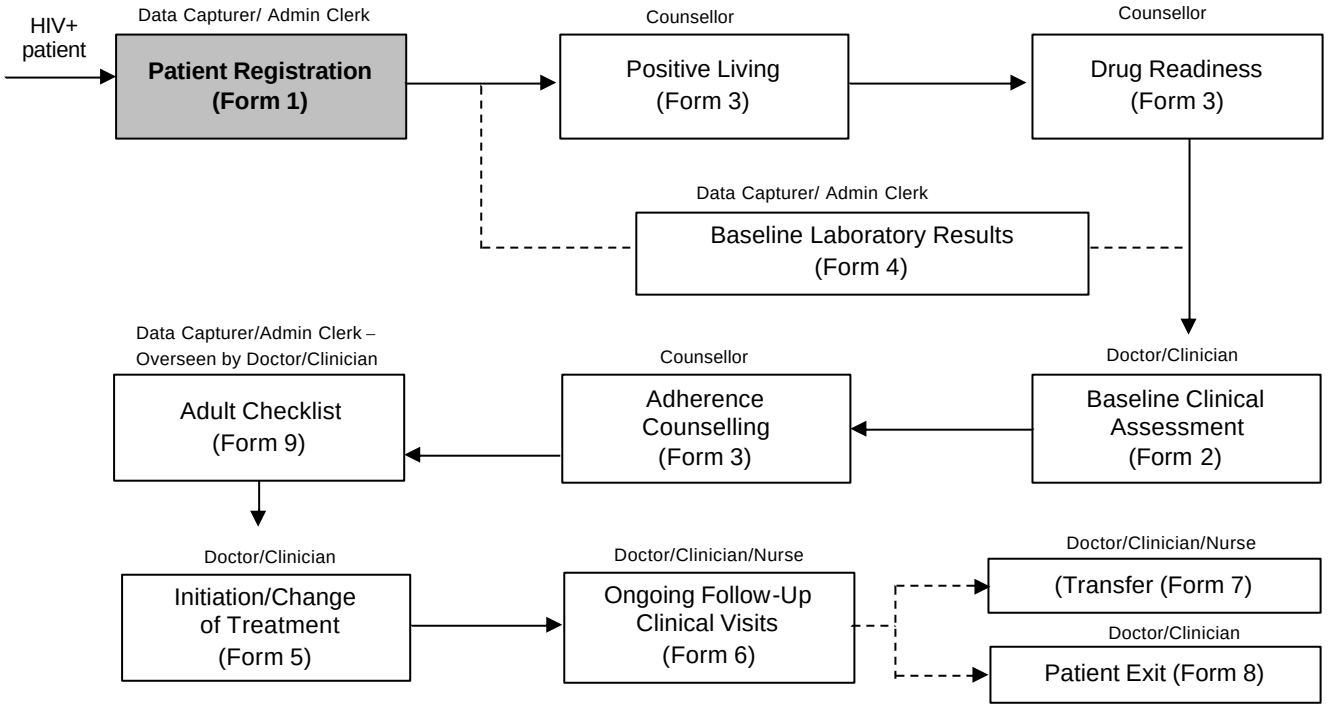


1. FORM 1: ADULT PATIENT REGISTRATION

The ADULT PATIENT INFORMATION FORM (FORM 1) contains all the ESSENTIAL PATIENT INFORMATION.

This form is THREE pages in length and is completed by the Admin Clerk or Data Capturer.

Please ensure that the PATIENTS ID NUMBER and NAME is entered exactly as it is reflected in the Patient's ID book.



Patient must have their ID Book in order to be registered. ID numbers are always 13 digits long

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FORM 1: ADULT PATIENT REGISTRATION

NL = KwaZulu

Data Capturer)

South African ID Number: As recorded in patients ID book

Province: N L

Registration Date: d

For use if the Hospital has a File number system (if patient has a file number)

Patient Firstname:

Patient Surname:

Specify if patient is not receiving free Gov ARV Treatment

Middle Names:

Hospital File Number: *(if relevant)*

Site Code:

Each site has its own 3 letter site

Capturer:

First letter of Capturer's first name and first two letters of last name.
Eg. Eunice Gumede: EGU

Funding/Billing: ○ Government ○ Private/Other *(Specify):*

A. PATIENT DETAILS

1. Date of Birth: d d / m m / y y y y

2. Gender: ○ Male ○ Female

3. Population Group: ○ Black ○ Coloured ○ Indian ○ White ○ Other *(Specify):*

Specify which country patient has

4. Citizenship/Residence Status: ○ South African ○ Other

5. Home Language: ○ Zulu ○ Xho… ○ Afrikaans ○ Other *(Specify):*

Select ALL options that apply

Patient cannot understand, speak or read English

6. English Ability: ○ Understand ○ Speak Little ○ Spe… English Ability
(Fill all that apply)

Patient living with their partner

7. Marital Status: ○ Single ○ Married ○ Cohabiting

Who referred the patient to the site

…y: ○ VCT Site ○ Self-Referral ○ Inpatient ○ Traditional Healer
○ PMTCT Site ○ TB Clinic ○ Outpatient ○ Other *(Specify):*

8a. If Referred by VCT Site then Date of VCT: d d / m m / y y y y

8b. Place where VCT was done:

B. CONTACT D…TAILS

1. Primary Address *…l Address or Directions)*

The home where the patient lives (or mostly stays at). If there is no physical address, give specific directions on how to get there. WRITE SMALL

(Only enter numbers - No brackets or dashes)

Tel (home):

3. Tel (work):

Area:

Four Letter Code for each District

4. Tel (cell):

Postal Code:

District Code:

5. Tel (other):

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We need to ascertain if the patient visits another address on a regular basis (e.g. visits family at the farm for regular extended periods

C. ALTERNATIVE ADDRESS

1. Do you have another address that you visit regularly? ○ Yes ○ No

1a. If so, when do you go?

○ Monthly ○ Twice a year ○ Quarterly ○ Annually

○ Other *(Specify)*

1b. How long do you go for?

○ Less than a month

○ More than a month *(Specify)*

Important information to ensure sufficient treatment available during the time away from home

1c. Directions to your alternative address:

Give detailed instructions to find the address, especially in a rural area where no street names are available (e.g. turn left at green Telkom container, past Spaza shop…etc)

D. TRAVEL AND DISTANCE

1. How long does it take for you to come from home to the hospital:

○ Less than 30mins ○ 30mins to 1hr ○ 1hr to 2hrs ○ More

Assists in determining population distribution and potential adherence hindrances

1a. What will be your usual means of coming to the hospital: ○ Bus ○ Car
(Fill all that apply)

1b. What is the name of the nearest clinic to where you live:

Assists in determining population distribution and where new sites are required

A patient may have walked for 30km and then taken a taxi. This influences the quality of time it took. Fill in all options that apply for the trip from home to the hospital

E. CONTACT PERSONS

1. Who is your primary contact person/next of kin?

Name:

Address:

Area:

Postal Code **District Code**

Tel No:

Person who would be contacted first if the patient is unreachable

How are they related to you?

○ Partner
○ Family Member
○ Household Member
○ Friend
○ Health Care Provider
○ Employer
○ Other *(Specify)*

Important in order for person contacting patient to be sensitive to the relationship of the primary contact to the patient

HIV status disclosed to this person? ○ Yes ○ No

2. Who is your alternative contact person/next of kin?

Name:

Address:

Area:

Postal Code **District Code**

Tel No:

If the patient and their primary contact is unreachable

How are they related to you?

○ Partner
○ Family Member
○ Household Member
○ Friend
○ Health Care Provider
○ Employer
○ Other *(Specify)*

HIV status disclosed to this person? ○ Yes ○ No

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This answers to this disclosure section must include the disclosure to the primary and alternative contacts already answered on page (section E).

F. DISCLOSURE

1. Have you disclosed your HIV status to anyone? *(Include the contacts given in section E)* ○ Yes ○ No

If Yes, please fill in the table below:

Disclosed To *(Fill all that apply)*	Supportive		Treatment Buddy			Supportive		Treatment Buddy	
	Yes	No	Yes	No		Yes	No	Yes	No
Partner	○		○	○	Health Care Provider	○	○	○	○
Family Member	○		○	○	Employer	○	○	○	○
Household Member	○		○	○	Other:				
Friend	○								

Is this person the patient's treatment buddy?

Is the person supportive to the patient's HIV status?

Specify the type of Other e.g. Work Colleague

G. SOCIAL SECURITY GRANTS

1. Have you ever attended school? ○ Yes ○ No

Gr7 (Std 6) to Gr11 (Std 9) *(Not Matric)*

1a. If so, what level of education do you have? ○ Primary ○ High School ○ Matric ○ Tertiary

2. Are you currently employed? ○ Yes ○ No

3. How many adult dependents are living in your home? ☐☐ *(Unemployed Adults)*

Number of adults the patient is responsible for taking care of

4. How many child dependents are living in your home? ☐☐

Number of children the patient is responsible for taking care of

4a. How many have been tested for HIV? ☐☐

4b. How many are HIV positive? ☐☐

4c. How many are on ARV Treatment? ☐☐

To ascertain the need for treatment

5. Are you the recipient of a Social Security Grant(s)? ○ Yes ○ No *(If in doubt refer to a social worker - Question 5b)*

If uncertain if patient qualifies for any grants – refer to Social worker

5a. If Yes, what type Grant(s) do you receive?

○ Old Age Grant ○ Care Dependency Grant

○ Disability Child Support Grant ☐☐ *(Specify for how many children)*

○ Social Rel oster Care Grant ☐☐ *(Specify for how many children)*

Provide the patient with an information pamphlet on the Grants available

5b. Refer to a social worker? ○ Yes ○ No *(For Grant Application/Home Affair Assistance)*

Refer to a Social Worker if you suspect the patient needs assistance in this area

H. DOMESTIC FACILITES

1. W ype of Water Supply do you have in your home? ○ Piped Water in Home ○ Communal Tap ○ Surface Water

2 pe of Sanitation do you have at home? ○ Flushing Toil ○ VIP *(Non-Flushing Outside Toilet)*

me? ○ Yes ○ No

o you use at home? ○ Wood ○ ectrical Stove

Important in assessing reasons for non-adherence or contributory factors to health deterioration

Availability of water for taking drugs

Positive Living Date: *(Patient Literacy 1)* d d / m m / y y y y **Time:** h h : m m *(24 hrs - eg. 13:30)*

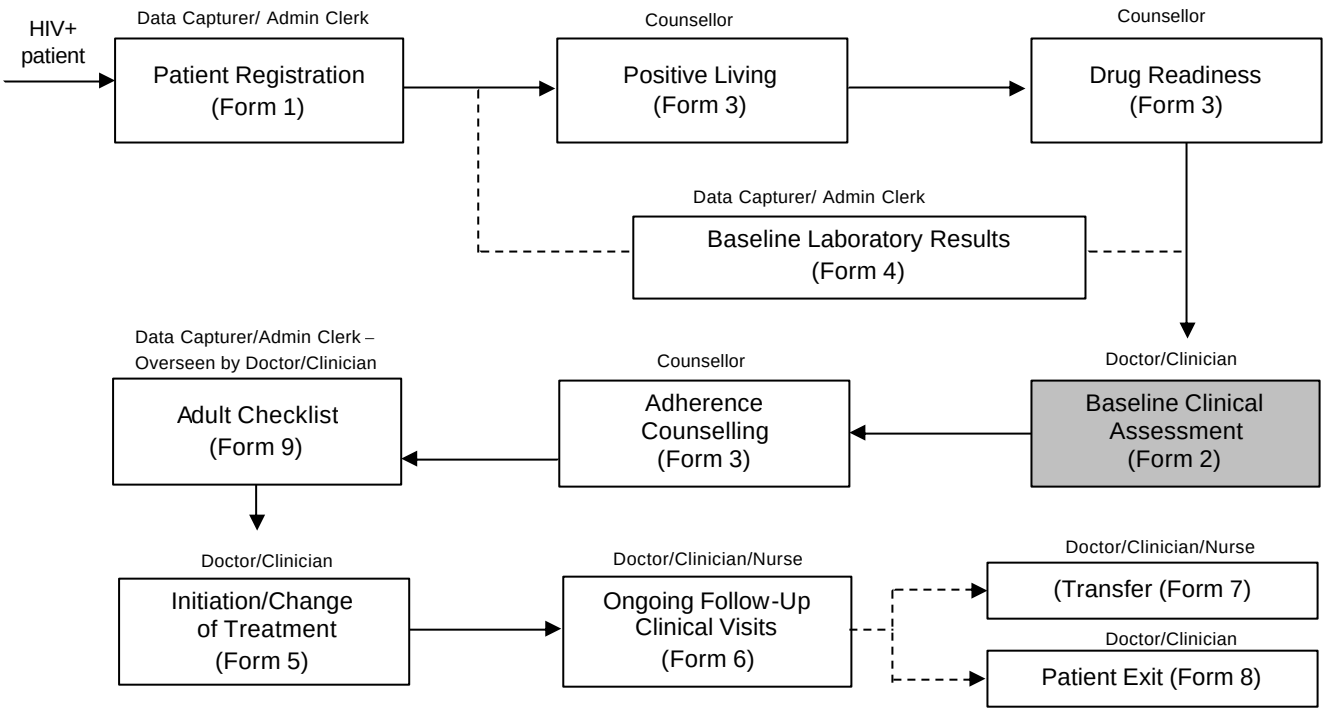
Time entered with four digits from 01:00 to 24:00. Eg. A quarter past five in the afternoon is entered as 17:15

Form 1: Adult Patient Registration
Page 3 of 3

2. FORM 2: ADULT BASELINE CLINICAL EXAMINATION

The ADULT BASELINE CLINICAL EXAMINATION FORM (FORM 2) contains the information collected during the patient's baseline examination perfo rmed by the doctor.

This form is FIVE pages in length and is completed by the Clinician / Doctor.



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FORM 2: ADULT BASELINE CLINICAL EXAMINATION

(Form filled in by Clinician)

South African ID Number: | | | | | | | | | | | | | **Capturer:** | | | **Date of Visit:** d d / m m / y y y y

A. CURRENT/PREVIOUS ARV MEDICATION

1. Is the patient on any antiretroviral therapy at present or have they taken ARVs in the past? O Yes O No

If Yes, specify the type of ARV Exposure: *(If Yes, refer to Specialist Site - Section K)*

O PMTCT → If known, what was taken: O Single Dose NVP O Double Dose NVP

O PEP → If PEP specify: **Treatment Start Date:** d d / m m / y y y y **Treatment End Date:** d d / m m / y y y y

O ARV Clinical Research Trials → What ARVs were taken and for how long:

O ARVs for Treatment → What ARVs were taken and for how long:

If any of the options in 'Section A' are selected then the patient MUST be referred to a specialist site

Indicate by ticking 'Specialist Site' option in the referral section on page 5 of this form

Comments:

B. HOSPITALISATION AND MEDICATION

1. Has the patient been hospitalised within the last year? O Yes O No **1a. If so, how many times:**

If so, please give the reasons:

This includes any reason for hospitalisation in the last

2. Has the patient been taking any medication other than ARVs? O Yes O No

Medication		Current Use	Comments
Cotrimoxazole (Bactrim)		O Yes O Unknown	
Fluconozole (Diflucan)		O Yes O Unknown	
Traditional Medicine		O Yes O Unknown	
Nutritional Supplements:	MVIs	O Yes O Unknown	
	Other	O Yes O Unknown	Specify:
Other 1 (specify):		O Yes O Unknown	
Other 2 (specify):		O Yes O Unknown	

Multi Vitamins

State the name of the Nutritional Supplement

State the name of the Medication

Indicate by ticking 'Dietician' in the referral option on page 5 of this form

3. Has the patient had a Nutritional Assessment? O Yes O No *(If No, refer to a Dietician - Section K)*

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PLEASE NOTE that questions 2 to 5 are for WOMEN only

C. FAMILY PLANNING

Questions 2 to 5 are for **women** only

1. Is the patient using any means of contraception? ○ Yes ○ No

1a. If Yes, please specify which form of contraception is being used:

○ Condoms ○ Oral Contraceptives ○ Injectables ○ Tubal Ligation ○ Other *(Specify)* _____

2. Date of Last Menstrual Period: _____ *(If Unsure or LMP was more than 6wks ago then order Pregnancy Test - Section J)*

3. How many times has the patient been pregnant (Parity)? ☐☐

4. How many children has the patient given birth to (Gravidity)? ☐☐ *(Only include live births)*

5. When did she have her last PAP smear?

○ Less than a year ago ○ Between 1yr and 2yrs ○ Between 2yrs and 3yrs ○ More than 3yrs ○ Never Had

D. TUBERCULOSIS

1. Is the patient currently being treated for Tuberculosis?

○ No *(Specify)* →

Has the patient had Tuberculosis in the last year? ○ Yes ○ No

1a. If Yes, for how long was the patient on TB Treatment? _____

1b. Was the Treatment completed? ○ Yes ○ No

○ Yes *(Specify)* →

When was TB Treatment started: d d / m m / y y y y

Date Treatment was last taken: d d / m m / y y y y

If only the month and year are known then type the digits '99' for the day

2. How many people living in the patient's home have been screened for TB: ☐☐

3. How many living in the patient's home are currently on TB Treatment: ☐☐

E. SYMPTOM HISTORY

Indicate which of the following symptoms have been experienced by the patient in the last month:

Symptom/Sign	Yes	Symptom/Sign	Yes
Weight Loss	○	Abdominal Pains	○
Fatigue	○	Nausea/Vomiting	○
Thrush	○	Headache	○
Rash	○	Visual Changes	○
Cough	○	Dizziness	○
Night Sweats	○	Altered sensation in the extremities	○
Fever	○	Vaginal/Penile discharge, itching or burning	○
Shortness of Breath	○	Change in mood	○
Jaundice	○	Other:	
Diarrhoea	○	Other:	

Extremities are hands and feet

Specify what the other symptom / sign

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67kg's is entered as 067.0kgs

F. PHYSICAL EXAMINATION

Height . m

Weight . kgs

157cm will be entered as 1.57m

BMI calculation

BODY MASS INDEX

Temperature . °C

BMI Weight / (Height)^2 .

Blood Pressure

Systolic

Diastolic

Examinations	Normal	Abnormal	Comments/Descriptions
Hydration	○	○	
Jaundice	○ No	○ Yes	
Colour	○	○ Cyanosis ○ Pale	
Oedema	○	○	
Ear, Nose & Throat	○	○	
Head & Neck	○	○	
Cardiovascular	○	○	
Lungs	○	○	
Abdomen	○	○	
Lymph Nodes	○	○	
Skin	○	○	
Urogenital	○	○	
Musculoskeletal	○	○	
Neurological	○	○	
Other *(Specify):*	○	○	
Other *(Specify):*	○	○	

Comments:

Form 2: Adult Baseline Clinical Examination
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WHO = WORLD HEALTH ORGANISATION

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Please select all that apply

G. WHO STAGE INDICATOR

1. Does the patient have any of these conditions:

WHO Stage 1	Yes	WHO Stage 4	Yes
Asymptomatic HIV Infection	○	Candidiasis *(Esophageal, Bronchi, Trachea or Lungs)*	○
Persistent Generalised Lymphadenopathy	○	Cryptococcosis, Extrapulmonary	○
WHO Stage 2		Cryptosporidiosis with Diarrhoea *(>1 month duration)*	○
Herpes Zoster *(within last 5 years)*	○	Cytomegalovirus Disease	○
Minor Mucocutaneous Manifestations	○	Herpes Simplex	○
Recurrent Upper Respiratory Tract Infections	○	HIV Encephalopathy	○
Weight Loss ≤ 10% of Body Weight	○	HIV Wasting Syndrome	○
WHO Stage 3		Kaposi's Sarcoma (KS)	○
Severe Bacterial Infections *(within last 5 years)*	○	Lymphoma	○
Oral Candidiasis (Thrush)	○	Atypical Mycobacteriosis, Disseminated	○
Unexplained Chronic Diarrhoea (>1 month)	○	Mycosis, Disseminated Endemic *(ie. Histoplasmosis, Coccidiodomycosis...)*	○
Unexplained Prolonged Fever *(Intermittent or constant > 1 month)*	○	Tuberculosis, Extrapulmonary	○
		Pneumocystis Pneumonia (PP)	○
Oral Hairy Leukoplakia	○	Progressive Multifocal Leukoencephalopathy (PML)	○
Tuberculosis, Pulmonary *(Within the last year)*	○	Salmonella Septicemia, Non-typhoid	○
Weight Loss > 10% of Body Weight	○	Toxoplasmosis, CNS	○

2. What is the patient's highest WHO Condition:

○ WHO Stage 1 ○ WHO Stage 2 ○ WHO Stage 3 ○ WHO Stage 4

Comments

H. WHO PERFORMANCE STAGE (Functional Status)

The patient has no physical limitations (they can function normally)

1. What is the patient's fuctional status:

1 ○ No Limitations (asymptomatic, normal activity)

2 ○ Ambulatory (able to bathe, eat, dress without assistance)

3 ○ In bed more than usual (but < 50% of normal daytime during the previous month)

4 ○ Bedridden (> 50% of normal daytime during previous month)

Comments

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I. NON ARV MEDICATIONS

1. Are there any non-ARV medicines that need to be ordered/changed? ○ Yes ○ No

If Yes, please indicate which are to be ordered and which are to be changed:

Medication		Recommendation Start	Stop	Continue	Comments
Cotrimoxazole (Bactrim)		○	○	○	
Fluconozole (Diflucan)		○	○	○	
Traditional Medicine		X	○	X	
Nutritional Supplements:	MVIs	○	○	○	
	Other	○	○	○	Specify:
Other 1 (specify):		○	○	○	
Other 2 (specify):				○	

Traditional Medicine MUST be discontinued

Multi Vitamins

J. LAB INVESTIGATIONS (To Order)

- ○ Viral Load
- ○ FBC
- ○ LFTs
- ○ Chemistries
- ○ Pregnancy Test
- ○ PAP Smear
- ○ Hepatitis B Rapid Test
- ○ TB Sputum (AFB)
- ○ Chest X-Ray
- ○ Other *(Specify):*

K. REFERRALS

Reason for Referral

- ○ Social Work
- ○ Counselling
- ○ TB Clinic
- ○ Inpatient/Hospital
- ○ Antenatal
- ○ Dietician
- ○ Specialist/Nodal Site *(Specify name of Site and Reason)*
- ○ Other *(Specify name of referral and Reason)*

Select all the referrals that are required for the patient as determined during this in the Baseline Clinical Examination

This is not the actual order form for lab investigations, but rather specifies which test were/need to be ordered via the hospital's existing system.

This is for information purposes ONLY

Tick to indicate which lab investigations have been ordered via your normal hospital lab system

Comments:

Next Appointment Date: d d / m m / y y y y **Time:** h h : m m *(24 hrs - eg. 13:30)*

Form 2: Adult Baseline Clinical Examination
Page 5 of 5

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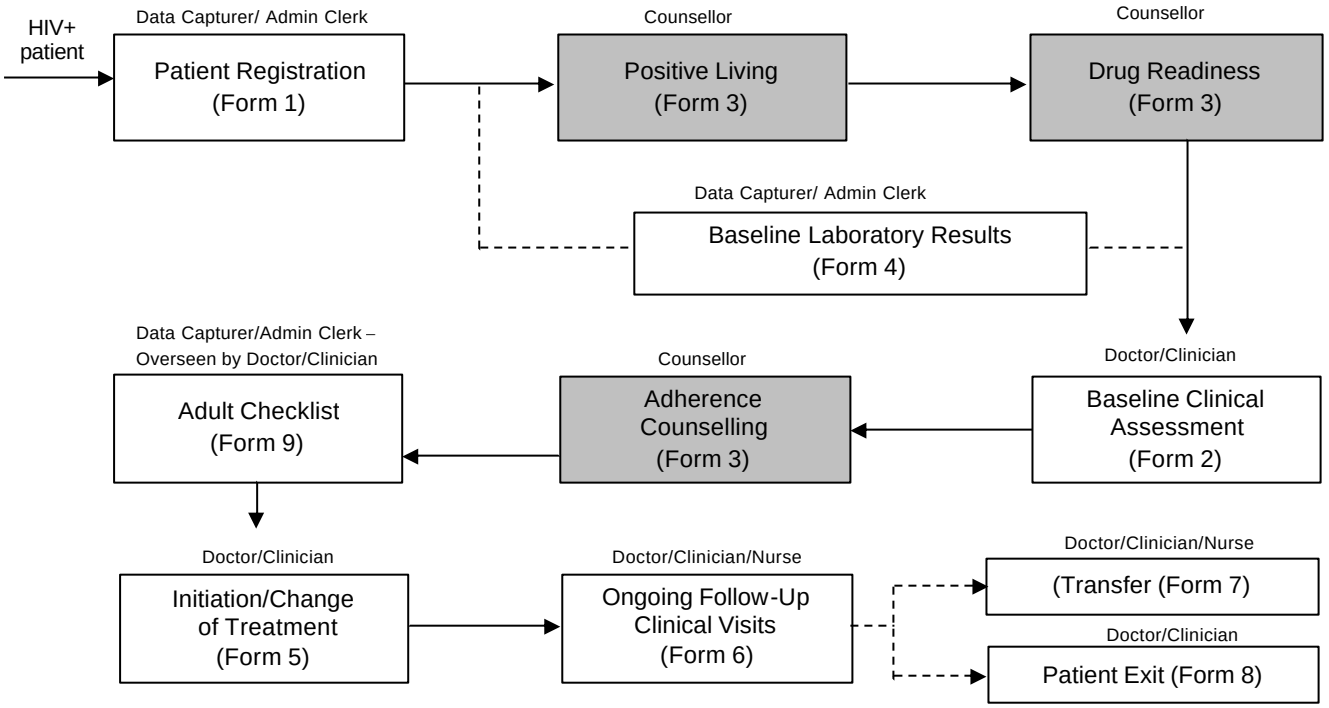
3. FORM 3: ADULT PATIENT COUNSELLING FORM

The ADULT PATIENT COUNSELLING (FORM 3) contains the information regarding the training courses the patient has attended; information regarding the people the patient has disclosed his/her HIV status to; and the name of the patient's treatment supporter.

This form is ONE page in length and is completed by the Counsellor.



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FORM 3: ADULT PATIENT COUNSELLING FORM

(Form filled in by Counsellor)

Counsellor

South African ID Number: | **Capturer:** | **Date of Visit:** d d / m m / y y y y

Enter the date this training course was attended

Counsellor's name / initials

A. GROUP COUNSELLING SESSIONS

Positive Living/Patient Literacy 1

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	○ Yes ○ No	d d / m m / y y y y	

Drug Readiness/Patient Literacy 2

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	○ Yes ○ No	d d / m m / y y y y	

Drug Adherence

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	○ Y	/ m / y y y y	

Nutritional Assessment

Due Date			Counsellor
d d / m m / y y y y	○	/ y y y y	

Specify any other treatment training course attended by the patient at your site.

Specify any training courses repeated by the patient

Other Patient Training *(Specify)* →

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	○ Yes ○ No	d d / m m / y y y y	

B. DISCLOSURE

1. Has the patient disclosed to anyone? ○ Yes ○ No

If Yes, to whom:

- ○ Partner
- ○ Family Member
- ○ Household Member
- ○ Friend
- ○ Health Care Provider
- ○ Employer
- ○ Other *(Specify)*

C. TREATMENT SUPPORTER

Name:

Address:

Who is the patient's treatment supporter?

Tel (work):

Tel (cell):

Is the patient contactable? ○ Yes ○ No

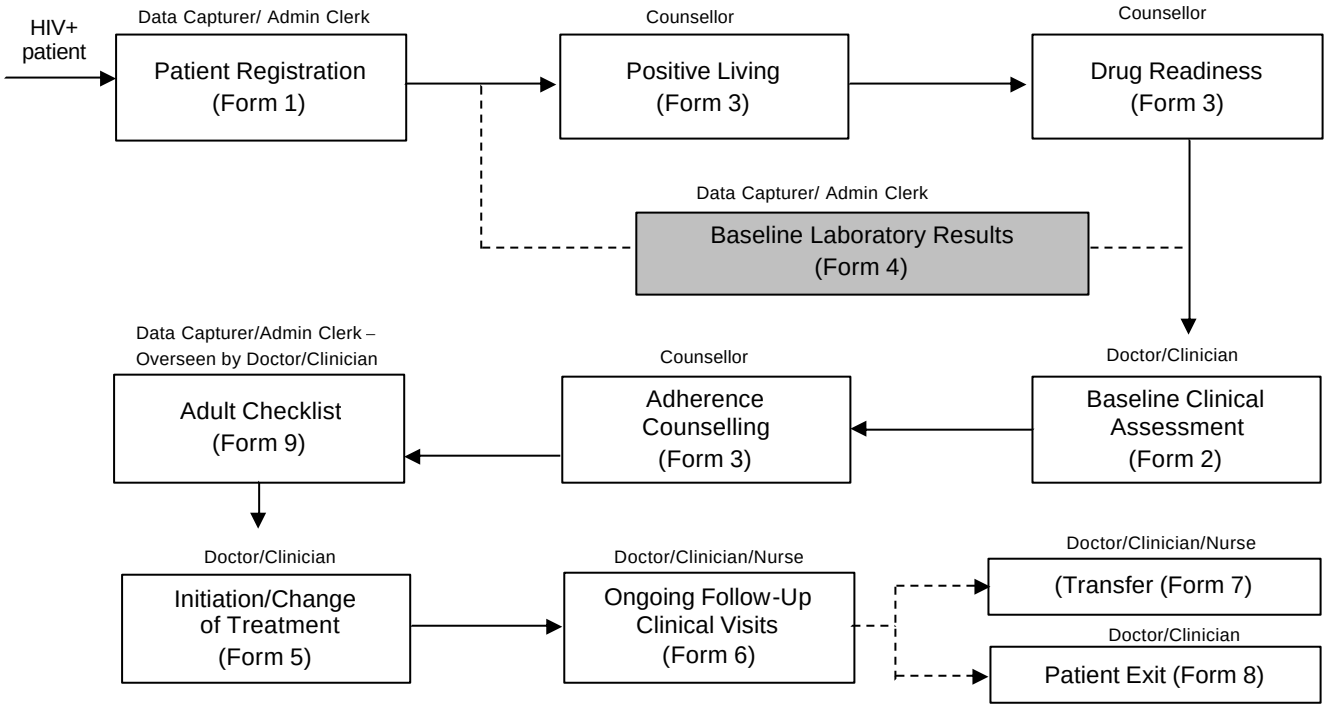
Comments:

4. FORM 4: ADULT BASELINE LABORATORY FORM

The ADULT BASELINE LABORATORY FORM (FORM 4) contains the information regarding all tests requested by the clinician as well as the results of these tests.

PLEASE NOTE this form is not the order form itself. All tests requested by the clinician must be processed via the hospital's existing laboratory test ordering mechanism (i.e. complete necessary paper work). Once these test results are received back from the lab, the admin clerk or data capturer is then responsible for recording them on this data collection form.

This form is ONE page in length and is completed by the Admin Clerk / Data Capturer.



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FORM 4: ADULT BASELINE LABORATORY RESULTS

(Form filled in by Admin Clerk/Data Capturer - Selections made by Clinician)

South African ID Number: | **Capturer:** | **Date Baseline Bloods Taken:** d d / m m / y y y y

A. CD4 RESULT

Laboratory Site:

CD4 Abs: /mm^3

Date Tested: d d / m m / y y y y

The Clinician must select the test/s that he/she has ordered via the hospitals ordering system.
The Data Capturer is then able to see which test/s results are outstanding from the lab

Once the test result is received from the lab, the data capturer is responsible for entering the result from the lab system onto this form

10^9/L

g/dl

Platelets 10^9/L

AST IU/L

Alk Phos IU/L

GGT IU/L

D. CHEMICAL PATHOLOGY

Sodium (Na+) me^3/L

Potassium (K+) mmol/L

Creatinine umol/L

Urea mmol/L

Amylase IU/L

Fasting Cholestrol mmol/L

Fasting Glucose mmol/L

Triglycerides mmol/L

E. TURBERCULOSIS

Sputum 1: Positive Negative

Sputum 2: Positive Negative

Chest X-Ray:

F. OTHER TESTS

Hepatitis B: Yes No

(If Yes, please specify)

Date Tested: d d / m m / y y y y

Result: Positive Negative

	Other Tests:	Date Tested:	Result:
1]		d d / m m / y y y y	
2]		d d / m m / y y y y	

Specify any other test ordered for the patient

G. VIROLOGY

Laboratory Site:

Viral Load: copies/ml

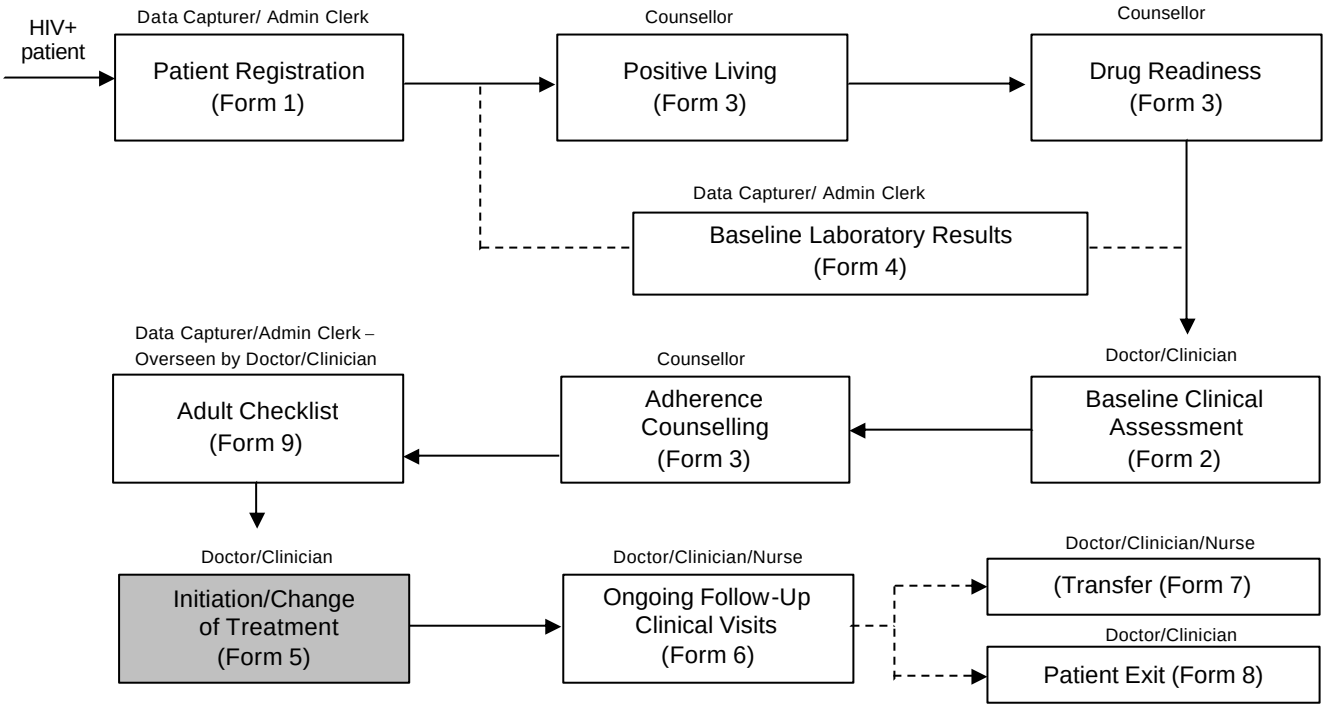
Date Tested: d d / m m / y y y y

5. FORM 5: ADULT INITIATION / CHANGE OF TREATMENT

The ADULT INITIATION / CHANGE OF TREATMENT FORM (FORM 5) is the form used for the initiation of the patient's ARV treatment and is also used for any change to the patient's ARV treatment schedule.

PLEASE NOTE this is not intended to be an actual prescription form. The Clinician is therefore still required to complete their usual hospital prescription documentation to ensure medication is dispensed.

This form is ONE page in length and is completed by the Clinician.



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FORM 5: ADULT INITIATION/CHANGE OF TREATMENT

(Form filled in by Clinician)

South African ID Number: | | | | | | | | | | | | | **Clinician:** | | | **Treatment Start Date:** d d / m m / y y y y

ARV Treatment: ○ First Dose of Treatment ○ Regimen Change ○ Drug Substitution *(If Drug Substitution answer Section B)*

A. DRUG REGIMENS

1. Is the patient a shift worker? ○ Yes ○ No

If a patient is a shift worker he/she may not be prescribed Regimen 1a

2. Please indicate which Regimen the patient is to start treatment on:

Regimen	Drug	Dose	Duration	Signature	Comments
○ 1a	Lamivudine (3TC)	150mg/bd			
	Stavudine (D4T)				
	Efavirenz (EFV)	600mg/nocte			

Please enter dosage

Regimen	Drug	Dose	Duration	Signature	Comments
○ 1b	Lamivudine (3TC)				
	Stavudine (D4T)				
	Nevirapine (NVP)				

Clinician's signature

Regimen	Drug	Dose	Duration	Signature	Comments
○ 2	Didanosine (ddl)				
	Zidovudine (AZT)	300mg/bd			
	Lopinavir/Rotonavir (LPV/r)				

B. DRUG SUBSTITUTION *(List all the drugs in the modified regimen)*

Drug	Dose	Duration	Signature	Comments

List all the drugs that make up the modified regimen

Comments:

Enter the time the ARV medication is going to be taken by the patient in the morning and the evening. This will help the counsellor with re-enforcing adherence

C. ARV DOSAGE TIMES

What time has the patient decided to take their ARVs:

In the Morning: h h : m m *(24 hrs - eg. 07:30)*

In the Evening: h h : m m *(24 hrs - eg. 19:30)*

Form 5: Adult Initiation/Change of Treatment
Page 1 of 1

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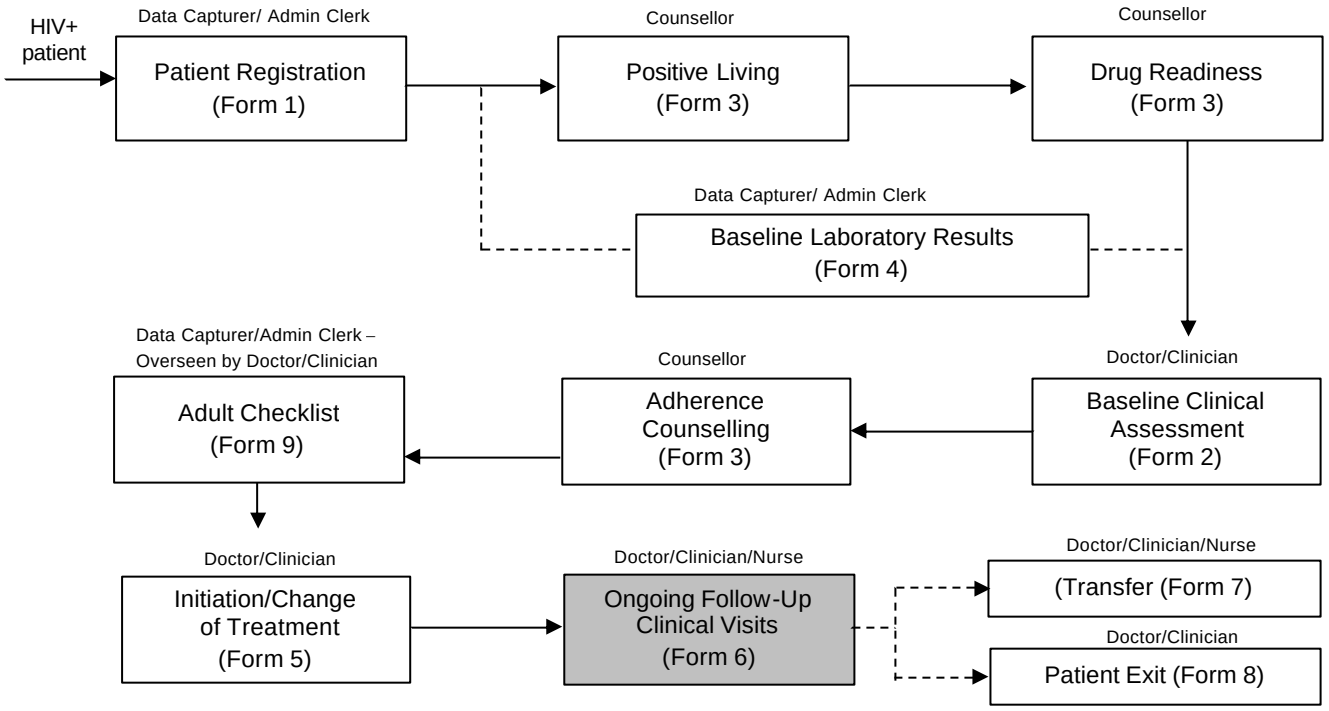
6. FORM 6: ADULT PATIENT FOLLOW-UP

The ADULT PATIENT FOLLOW-UP FORM (FORM 6) is the form used for all follow-up clinical examinations once the patient has started ARV treatment.

This form is FIVE pages in length and is completed by the Clinician.



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Comprehensive Care Programme

FORM 6: ADULT PATIENT FOLLOW-UP

(Form filled in by Clinician)

South African ID Number: | | | | | | | | | | | | | **Clinician:** | | | **Date of Visit:** d d / m m / y y y y

Type of Visit: ○ Scheduled ○ Unscheduled

A. WHO PERFORMANCE STAGE (Functional Status)

1. How has the patient been feeling since the last visit:

The patient has no physical limitations (they can function normally)

1 ○ No Limitations (asymptomatic, normal activity)

2 ○ Ambulatory (able to bathe, eat, dress without assistance)

3 ○ In bed more than usual (but < 50% of normal daytime during the previous month)

4 ○ Bedridden (> 50% of normal daytime during previous month)

B. SYMPTOM LIST

Indicate which of the following symptoms the patient has experienced since the last visit:

Symptom/Sign	Yes	Symptom/Sign	Yes
Weight Loss	○	Abdominal Pains	○
Fatigue	○	Nausea/Vomiting	○
Thrush	○	Headache	○
Rash	○	Visual Changes	
Cough	○	Dizziness	
Night Sweats	○	Altered sensation in the extremities	
Fever	○	Vaginal/Penile discharge	
Shortness of Breath	○	Change in mood	
Jaundice	○	Other:	○
Diarrhoea	○	Other:	○

Please specify any other symptom or sign the patient is experiencing since their last visit

This is hospitalisation related or unrelated to the ARV treatment

C. HOSPITALISATION

1. Has the patient been hospitalised since their last visit? ○ Yes ○ No

Question 1 is for WOMEN ONLY

If Yes, please give the reasons:

_____

_____

D. PREGNANCY AND FAMILY PLANNING

Question 1 is related to **women** only

1. Date of Last Menstrual Period: _____

(If Unsure or LMP was more than 6wks ago then order Pregnancy Test - Section L)

2. Is the patient using any means of contraception? ○ Yes ○ No

2a. If Yes, please specify which form of contraception is being used:

○ Condoms ○ Oral Contraceptives ○ Injectables ○ Tubal Ligation ○ Other *(Specify):* _____

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This is a critical section which is followed up by the Counsellor.

E. ADHERENCE

1. How many doses has the patient missed since the last visit?

○ None ○ One ○ Two ○ Three ○ More than Three

1a. Why did the patient miss their doses?

○ Side Effects	○ Patient ran out of pills
○ Transportation Issues	○ ARV site ran out of medicine
○ Forgot	○ Disclosure or privacy issues
○ Felt too ill	○ Other *(Specify)* →

2. Is the patient wanting to stop taking ARVs? ○ Yes ○ No

3. Has anything changed in the patient's routine that may affect adherence? ○ Yes ○ No

3a. If Yes, what has changed:

_____

_____

See section M on page 5 of this form to indicate referral to Adherence Team.

4. Do you have concerns about the patient's adherence? ○ Yes ○ No

4a. Should the Adherence Counsellors be informed? ○ Yes ○ No *(If Yes, refer to Adherence Team - Section M)*

F. PHYSICAL EXAMINATION

Height ☐☐.☐☐ m

Weight ☐☐☐.☐ kgs

BMI= Body Mass Index

Temperature ☐☐.☐ °C

BMI Weight / (Height)² ☐☐☐.☐☐

Blood Pressure

Systolic ☐☐☐

Diastolic ☐☐☐

Examinations	Normal	Abnormal	Comments/Descriptions
Hydration	○	○	
Jaundice	○ No	○ Yes	
Colour	○	○ Cyanosis ○ Pale	
Oedema	○	○	
Ear, Nose & Throat	○	○	
Head & Neck	○	○	
Cardiovascular	○	○	
Lungs	○	○	
Abdomen	○	○	
Lymph Nodes	○	○	
Skin	○	○	
Urogenital	○	○	
Musculoskeletal	○	○	
Neurological	○	○	
Other *(Specify)*	○	○	
Other *(Specify)*	○	○	

There is space for comments on the top of the next page

(See top of next page - Page 3 - to note any Physical Examination comments)

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G. PHYSICAL EXAMINATION NOTES/COMMENTS

H. TOXICITY MONITORING/ADVERSE EVENTS

SYMPTOMS	YES	GRADE 1	2	3	4	COMMENTS
Gastrointestinal						
Loss of Appetite	○	○	○	○	○	
Nausea	○	○	○	○	○	
Vomiting	○	○	○	○	○	
Diarrhoea	○	○	○	○	○	
Abdominal Pain	○	○	○	○	○	
Jaundice	○	○	○	○	○	
Dermatological						
Rash	○	○	○	○	○	
Blisters	○	○	○	○	○	
Mouth Sores	○	○	○	○	○	
Nervous Systems						
Numbness/ Tingling in hands and feet	○	○	○	○	○	
Difficulty Sleeping	○	○	○	○	○	
Mental Dullness/ Lack of Concentration	○	○	○	○	○	
Bad Dreams	○	○	○	○	○	
Dizziness	○	○	○	○	○	
Other *(Specify):*	○	○	○	○	○	
Fever	○	○	○	○	○	
Other *(Specify):*	○	○	○	○	○	

Please indicate the severity of the symptom experienced by the patient by entering the respective grade

Please specify if there are any other symptoms related to the nervous s ystem

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I. WHO STAGE

Enter the patient's current World Health Organisation STAGE

1. What is the patient's WHO Stage:

O WHO Stage 1 O WHO Stage 2 O WHO Stage 3 O WHO Stage 4

J. CURRENT MEDICATIONS

1. Are there any changes to the patient's non-ARV medication? O Yes O No O Not on Medication

If Yes, please indicate changes or continuations on the table below:

Medication		Recommendation Start	Stop	Continue	Comments
Cotrimoxazole (Bactrim)		O	O	O	
Fluconozole (Diflucan)		O	O	O	
Traditional Medicine		X	O	X	
Nutritional Supplements:	MVIs	O	O	O	
	Other	O	O	O	
Other 1 (specify):		O	O	O	
Other 2 (specify):		O	O	O	

If there ARE ANY CHANGES to the non-ARV medication please specify below

All traditional medication to the DISCONTINUED

Comments:

_____

_____

_____

_____

_____

_____

K. OPPORTUNISTIC INFECTIONS

1. Has the patient had any opportunistic infections since the last visit? O Yes O No

If Yes, please specify which OI from the list below:

Opportunistic Infections	Yes	Anatomical Location *(Please specify)*
Herpes Zoster	O	
Oral Candidiasis (Thrush)	O	
Candida Esoephagitis	O	
Cryptococcal Meningitis	O	
Cryptosporidiosis with Diarrhoea	O	
Cytomegalovirus Disease	O	
Herpes Simplex	O	
Mycosis, Disseminated Endemic	O	
Tuberculosis, Extrapulmonary	O	
Pneumocystis Pneumonia (PP)	O	
Toxoplasmosis, CNS	O	
Other 1:	O	
Other 2:	O	

Please specify what part of the body is affected by the opportunistic infection

This is not an order for lab investigations.

This is for information purposes ONLY

Tick to indicate which lab investigations have been ordered for this patient via your normal hospital lab investigation system

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L. LAB INVESTIGATIONS

- ○ Viral Load
- ○ CD4
- ○ FBC
- ○ LFTs
- ○ Chemistries
- ○ Pregnancy Test
- ○ PAP Smear
- ○ Hepatitis B Rapid Test
- ○ TB Sputum (AFB)
- ○ Chest X-Ray
- ○ Other *(Specify):*

M. REFERRALS

Reason for Referral

- ○ Social Work
- ○ Adherence Counselling
- ○ TB Clinic
- ○ Inpatient/Hospital
- ○ Antenatal
- ○ Dietician
- ○ Specialist Clinic *(Specify name and reason)* →
- ○ Other *(Specify name and reason)* →

Select all the referrals that are required for the patient as determined during this in the Follow-up Examination

Has the patients health remained the same, improved or deteriorated since the last examination

N. ARV TREATMENT SUMMARY/ACTION

1. Summary of the patient's health: ○ Stable ○ Improvement ○ Deterioration

1a. If Deterioration specify the reason: ○ Disease Progression ○ Poor Adherence ○ Adverse Event

○ Other *(Specify):*

2. Is there to be any change in the ARV Treatment? ○ Yes ○ No

2a. If Yes specify the type of change:

○ Drug Substitution →

Name of Specialist Consulted:

Old Drug: New Drug:

Specify the name of the Specialist Consulted who authorised the drug substitution

○ Change Whole Regimen

Name of Specialist Consulted:

New Regimen:

○ Treatment Interrupted

Reason:

○ Resume Treatment

Indicate if this is a change to the whole Regimen. Specify the name of the Specialist Consulted to authorise the whole regimen change

○ Terminate Treatment

Complete Adult Patient Exit Form (Form 8)

If treatment is terminated then an EXIT form (Form 8) MUST be completed

Comments:

Next Appointment Date: d d / m m / y y y y **Time:** h h : m m *(24 hrs - eg. 13:30)*

Form 6: Adult Patient Follow-up
Page 5 of 5

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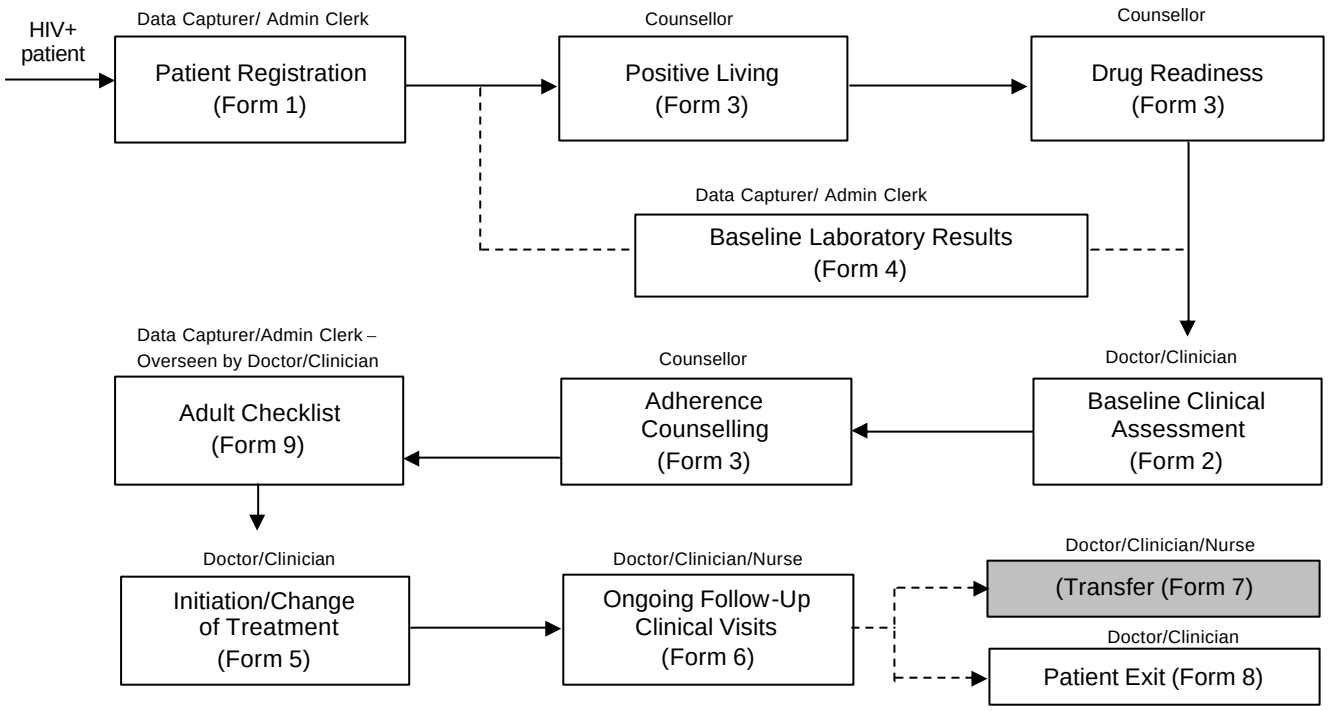
7. FORM 7: ADULT PATIENT TRANSFER FORM

The ADULT PATIENT TRANSFER FORM (FORM 7) is the form used when a patient is transferring out of the ARV treatment programme at your site and will be transferring into the ARV treatment programme at another South African Government site.

This form is for information purposes only (to track patient movement).

This form is ONE page in length and is completed by the Admin Clerk / Data Capturer.



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Comprehensive Care Programme

FORM 7: ADULT PATIENT TRANSFER FORM

(Form filled in by Admin Clerk/Data Capturer)

Transfer To: *(Name of new Treatment Site)* **Site Code:** **Date of Transfer:** d d / m m / y y y y

Province:
○ NL ○ EC ○ FS ○ GT ○ LP ○ MP ○ NC ○ NW ○ WC **District Code:**

Facility Type: **Telephone:** **Fax:**

Transfer From: *(Name of transfering Treatment Site)* **District Code:** **Province:** N L **Site Code:** **Capturer:**

Facility Type: **Telephone:** **Fax:**

A. PATIENT DETAILS

South African ID Number: **Telephone/Cell:**

Patient Firstname: **Patient Surname:**

B. REASON FOR TRANSFER

1. Please specify the reason for the transfer: ○ Closer Site ○ Change in Residential Address ○ Other

(If Other, Specify Reason)

C. CLINICIAN DETAILS *(Details of clinician approving/handling the Transference)*

1. Fullname of Clinician:

2. Tel (work):

3. Tel (fax):

4. Signature:

(This section is filled in by the Site receiving the patient)

Has the first appointment been made: ○ Yes ○ No *If Yes, when* d d / m m / y y y y

Date of receipt of Transfer Form: d d / m m / y y y y

Please fax/mail this section when completed to:

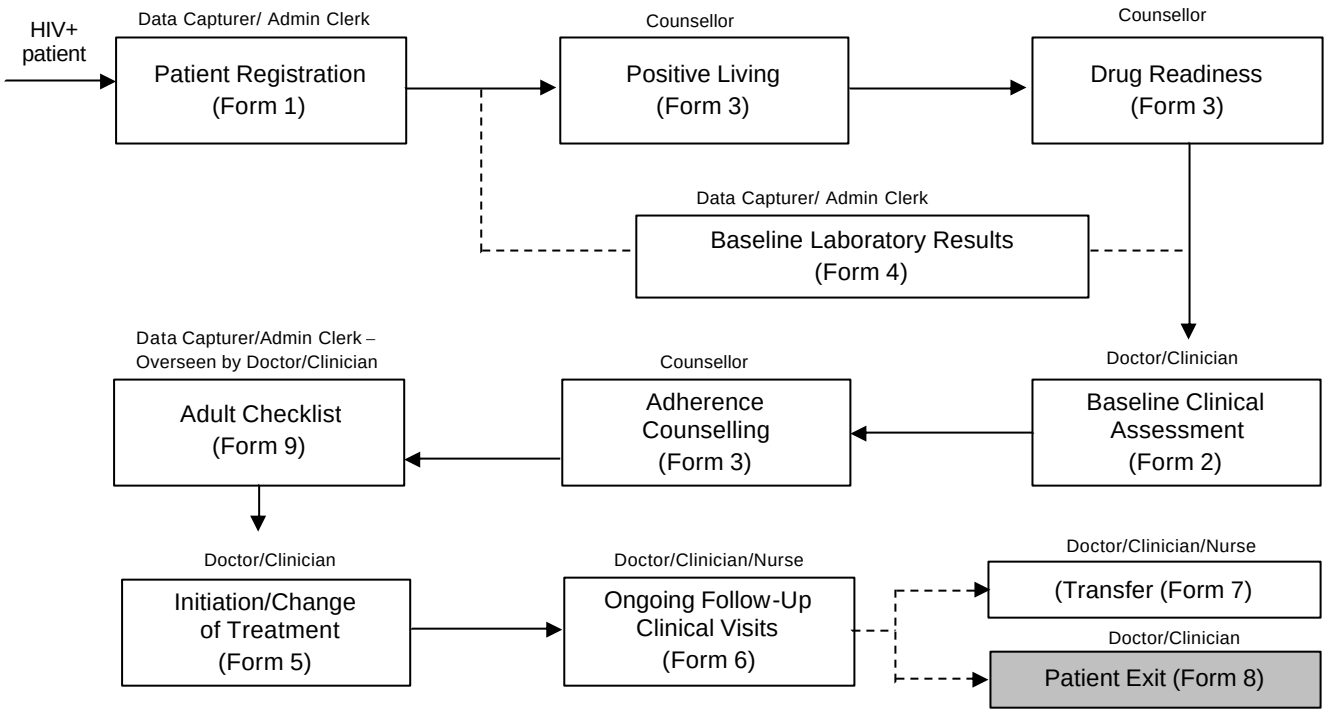
(Only enter numbers - No brackets or dashes)

Patient has attended first visit at new ART site: ○ Yes ○ No

8. FORM 8: ADULT PATIENT EXIT FORM

The ADULT PATIENT EXIT FORM (FORM 8) is the form used when a patient is EXITING the ARV treatment programme.

This form is ONE page in length and is completed by the Counsellor.



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FORM 8: ADULT PATIENT EXIT FORM

(Form filled in by Counsellor)

South African ID Number: | **Capturer:** | **Exit Date:** d d / m m / y y y y

A. REASONS FOR EXITING THE PROGRAMME

Please specify the reason for discontinuation from the programme:

- ○ Patient Request *(complete Section 1)*
- ○ Patient Deceased *(complete Section 2)*
- ○ Patient Defaulted *(complete Section 3)*

Please specify the reason for the patient discontinuing the programme

1. Patient requests to discontinue with the programme

1a. Date of Discontinuation: d d / m m / y y y y

1b. What were the reasons: _____

Please give as much detail as possible to describe the reason the patient requested to discontinue with the programme

2. Patient known/reported to be deceased

2a. Date of Death: d d / m m / y y y y

2b. Cause of death known: ○ Yes ○ No

If Yes, what was the cause: _____

2c. Source of Information:

○ Death Certificate ○ Friend/Relative ○ Hospital Records ○ Other *(Specify)* _____

3. Patient Defaulted

3a. Default Date: d d / m m / y y y y

3b. Please specify the contributory factors for Defaulting:

Factor	Yes	Options and Comments
Substance Abuse	○	○ Alcohol ○ Drugs *(Specify drug type/s)* :
Psychiatric Illness	○	○ Depression ○ Schizophrenia ○ Other :
Other Reasons *(Specify)*	○	

3c. Source of Information:

○ Patient ○ Friend/Relative ○ Other *(Specify)* _____

Comments:

_____

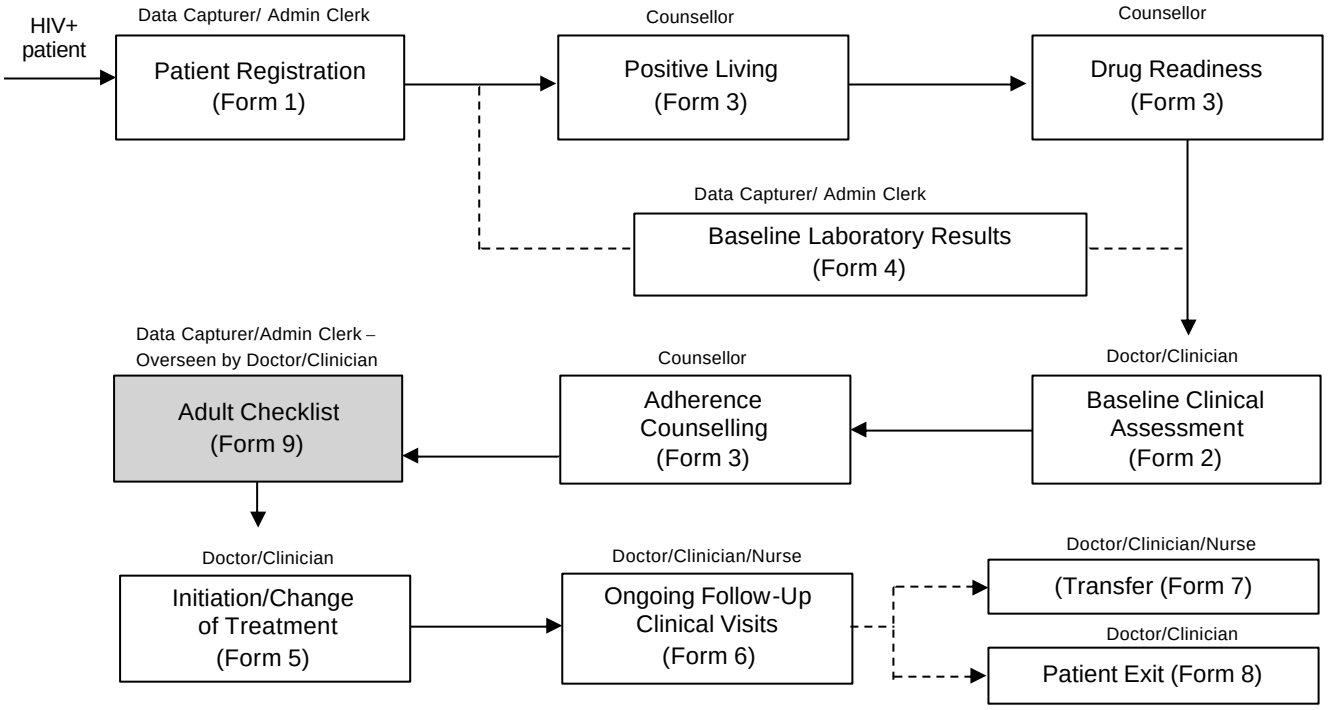
_____

_____

9. FORM 9: ADULT PATIENT CHECKLIST

The ADULT PATIENT CHECKLIST is the form used to record all the actions necessary before a patient can be determined 'drug ready' (i.e. ready to begin ARV treatment).

This is a ONE page checklist and is updated by the Admin Clerk / Data Capturer.



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Comprehensive Care Programme

FORM 9: ADULT PATIENT CHECKLIST

(Form filled in by Admin Clerk/Data Capturer and Clinician)

South African ID N

Each action must be answered with YES or NO

If the reply to an action is YES - please specify the date of the action and complete any required comments

ACTION	DONE	DATE	COMMENTS
Patient Registered	○ Yes ○ No	d d / m m / y y y y	
CD4 Count Taken	○ Yes ○ No	d d / m m / y y y y	/mm^3
WHO Staging	○ Yes ○ No	d d / m m / y y y y	WHO Stage
Bactrim Prescribed	○ Yes ○ No	d d	
Status Disclosed	○ Yes ○ No	d d	
Treatment Supporter	○ Yes ○ No	d d / m m / y y y y	
Positive Living	○ Yes ○ No	d d / m m / y y y y	
Drug Readiness	○ Yes ○ No	d d / m m / y y y y	
Drug Adherence	○ Yes ○ No	d d / m m / y y y y	
Baseline Bloods	○ Yes ○ No	y y y y	
Nutritional Assessment	○ Yes ○ No	d d / m m / y y y y	Supplements: ○ Yes ○ No
Patient Knowledge	1. Drug Names: ○ Yes ○ No	2. Drug Doses: ○ Yes ○ No	
TB Excluded	○ Yes ○ No	d d / m m / y y y y	
If No, TB treated for more than 2 months:	○ Yes ○ No	d d / m m / y y y y	
PAP Smear (women)	○ Yes ○ No	y y y y	
Hepatitus B Vaccine	○ Yes ○ No	y y y y	
Drug Ready	○ Yes ○ No	d d / m m / y y y y	
ARV Start Date		d d / m m / y y y y	Regimen Number:

Has the patient attended the 'Positive Living' , 'Drug Readiness' and 'Drug Adherence' training courses?

Does the patient know the drug names and doses he is taking?

The Clinician has ascertained that the patient does not have TB

If the patient has TB, have they been on TB treatment for more than 2 months

Is the patient ready to begin treatment?

Form 9: Adult Checklist
Page 1 of 1

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10. ADULT VISIT SUMMARY FORM

The ADULT VISIT SUMMARY is the summary that is located at the front of the patients file. The information in this summary is updated every visit. It gives the Clinician a one-page view of the past five visits showing the patient's vital information that helps to indicate if the patient has improved or deteriorated during the last month.

This is a one-page view summary that rolls-on to a new sheet once the current page is full. There is therefore a history from date of registration to track the patient's health.

This visit summary is updated by the Admin Clerk / Data Capturer.

SA ID Number

Hospital File Number

ADULT VISIT SUMMARY FORM

KwaZulu Natal Department of Health
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Visit Date		/ /	/ /	/ /	/ /	/ /
Scheduled (X=No; Tick=Yes)						
Date of Next Visit		/ /	/ /	/ /	/ /	/ /
WHO Staging						
WHO Performance						
Height (metres)						
Weight (kgs)						
BMI						
Temperature						
Blood Pressure (systolic/diastolic)		/	/	/	/	/
Bloods Taken (X=No; Tick=Yes)						
Blood Results	CD4 Count					
	Viral Load					
	Hb					
	WCC					
	Plts					
	ALT					
	GGT					
	Alk Phos					
	Cholestrol					
Other Tests	Test Type					
	Result					
Treatment Regimen						
Months on Treatment						
Months on Regimen						
Substitutions						
Opportunistic Infections	1					
	2					
	3					
	4					
Adverse Events/ Side Effects	Event / Grade					
	Event / Grade					
	Event / Grade					
	Event / Grade					
Change in Treatment Regimen						
OI Prophy - laxis	Cotrimoxazole					
	Fluconazole					
No. of Missed Doses		0 / 1 / 2 / 3 / >3	0 / 1 / 2 / 3 / >3	0 / 1 / 2 / 3 / >3	0 / 1 / 2 / 3 / >3	0 / 1 / 2 / 3 / >3
TB Symptoms (Tick=Yes)						
Months on TB Treatment						
Referrals (Tick=Yes)	Social Work					
	Counselling					
	TB Clinic					
	Inpatient/Hospital					
	Antenatal					
	Dietician					
	Specialist Clinic					
	Other *(specify)*					
Action						
Comments						
Captured By						