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:

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, itching or burning	○
Shortness of Breath	○	Change in mood	○
Jaundice	○	Other:	○
Diarrhoea	○	Other:	○

C. HOSPITALISATION

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

If so, 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):* _____

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	○ Clinic 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:

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**

Blood Pressure
Systolic ☐☐☐
Diastolic ☐☐☐

Temperature ☐☐.☐ **°C**

BMI $\frac{\text{Weight}}{(\text{Height})^2}$ ☐☐☐.☐☐

Examinations	Normal	Abnormal	Not Done	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)*	○	○	○	

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

G. PHYSICAL EXAMINATION NOTES/COMMENTS

H. TOXICITY MONITORING/ADVERSE EVENTS

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

I. WHO STAGE

1. What is the patient's WHO Stage:

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

J. CURRENT MEDICATIONS

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

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

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

Comments:

K. OPPORTUNISTIC INFECTIONS

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

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

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

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)* →
- ○ Other *(Specify)* →

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:

○ Change Whole Regimen →
Name of Specialist Consulted:
New Regimen:

○ Treatment Interrupted →
Reason:

○ Resume Treatment

○ Terminate Treatment → **Complete Adult Patient Exit Form (Form 8)**

Comments:

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