FORM 2: PAEDIATRIC BASELINE CLINICAL EXAMINATION

(Form filled in by Doctor/Clinician)

Birth Registration/SA 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 ARVs been taken in the past? ○ Yes ○ No *(If Yes, refer to nodal site)*

If Yes, specify the type of ARV Exposure:

○ PMTCT

○ PEP

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

Comments:

B. HOSPITALISATION

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

1b. If so, please give the last four reasons:

Reason	How Long	Comments
1]		
2]		
3]		
4]		

C. MEDICATION

1. Has the patient been taking any medication other than ARVs? ○ Yes ○ No

Medication		Current Use	Comments
Cotrimoxazole (Bactrim)		○ Yes ○ No	
Fluconozole (Diflucan)		○ Yes ○ No	
Traditional Medicine		○ Yes ○ No	
Nutritional Supplements:	MVTs	○ Yes ○ No	
	Other	○ Yes ○ No	*Specify:*
Other 1 *(specify):*		○ Yes ○ No	
Other 2 *(specify):*		○ Yes ○ No	

2. Has the patient been Dewormed? ○ Yes ○ No → **If Yes, date of last dose:**

3. Has the patient had Vitamin A dose? ○ Yes ○ No → **If Yes, date of last dose:**

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

D. TUBERCULOSIS

1. Is the patient currently being treated for Tuberculosis?

○ No *(Specify)* →

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

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

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

1c. Date Treatment was last taken: d d / m m / y y y y

○ Yes *(Specify)* →

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

E. PHYSICAL EXAMINATION

Height ☐☐☐ **cm**

Weight ☐☐☐.☐ **kgs**

BSA ☐.☐☐ **m²**

$$\sqrt{\frac{\text{(Weight x Height)}}{3600}}$$ (Weight in kg, Height in cm)

Temperature ☐☐.☐ **°C**

Head Circumference ☐☐.☐ **cm**

Examinations	Normal	Abnormal	Comments/Descriptions
JACCO	○	○	
Lymph Nodes	○	○	
Oral (teeth,mouth)	○	○	
Ears	○	○	
Parotids	○	○	
Cardiovascular	○	○	
Lungs	○	○	
Hepatosplenomegaly (Abdomen)	○	○	
Skin	○	○	
Neurological	○	○	
Other *(Specify):*	○	○	
Other *(Specify):*	○	○	

Comments:

KwaZulu Natal Department of Health
Comprehensive Care Programme

F. DEVELOPMENTAL MILESTONES

1. Does the patient meet the appropriate developmental milestones? ○ Yes ○ No

Examinations	Age	Normal	Abnormal	Comments
Gross Motor		○	○	
Fine Motor		○	○	
Language		○	○	
Social		○	○	
Scholasitc		○	○	

Comments:

G. PUBERTAL DEVELOPMENT

1. Does the patient meet the appropriate pubertal development milestones? ○ Yes ○ No

Examinations	Tanner Stage					Comments
	1	2	3	4	5	
Breast	○	○	○	○	○	
Pubic Hair	○	○	○	○	○	
Penis/Scrotum	○	○	○	○	○	

Comments:

H. STAGING

1. What is the patient's WHO Stage:

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

Comments:

KwaZulu Natal Department of Health
Comprehensive Care Programme

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		☒	○	☒	
Nutritional Supplements:	MVTs	○	○	○	
	Other	○	○	○	Specify:
Vitamin A		○	○	○	
Anthelminthic (Deworm)		○	○	○	
Other 1 (specify):		○	○	○	
Other 2 (specify):		○	○	○	

Comments:

____

____

____

J. LAB INVESTIGATIONS (To Order)

- ○ Viral Load
- ○ FBC
- ○ LFTs
- ○ TB Skin Test
- ○ AFB
- ○ Chest X-Ray
- ○ Lipids
- ○ Glucose
- ○ Hepatitis B (if >8yrs old)
- ○ Other *(Specify):*

K. REFERRALS

	Reason for Referral
○ Social Work	
○ Counselling	
○ TB Clinic	
○ Inpatient/Hospital	
○ Dietician	
○ Nodal Site *(Specify name and reason)* →	
○ Other *(Specify name and reason)* →	

Comments:

____

____

____

____

Is the patient ready to start ARV Treatment? ○ Yes ○ No

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