



FORM 3: PAEDIATRIC PATIENT COUNSELLING FORM

(Form filled in by Counsellor)

Birth Registration/SA ID Number:

--	--	--	--	--	--	--	--

--	--	--	--	--	--

--	--

Capturer:

--	--	--

Date of Visit:

d	d
---	---

/	m	m
---	---	---

/	y	y	y	y
---	---	---	---	---

A. GROUP COUNSELLING SESSIONS

Positive Living

Due Date

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Attend

Yes No

Date Attended

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Counsellor

--

Drug Readiness

Due Date

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Attend

Yes No

Date Attended

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Counsellor

--

Drug Adherence

Due Date

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Attend

Yes No

Date Attended

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Counsellor

--

Nutritional Assessment

Due Date

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Attend

Yes No

Date Attended

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Counsellor

--

Other Patient Training (Specify) →

--

Due Date

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Attend

Yes No

Date Attended

d	d	/	m	m	/	y	y	y	y
---	---	---	---	---	---	---	---	---	---

Counsellor

--

B. DISCLOSURE

1. To whom has the patient's HIV status been disclosed? (Fill all that apply)

Parent(s)

Household Member

Other (1) (Specify)

--

Family Member

Health Care Worker

Other (2) (Specify)

--

2. Is the patient aware of their HIV Diagnosis? Yes No

C. HOME ENVIRONMENT

1. How many people live with the patient?

--	--

2. How many are HIV Positive?

--	--

3. How many are enrolled in the Treatment Programme?

--	--