FORM 5: PAEDIATRIC PRESCRIPTION FORM

(Form filled in by Doctor)

Birth Registration/SA ID Number: | | | | | | | | | | | | | | **Clinician:** | | | **Treatment Start Date:** d d / m m / y y y y

A. DRUG REGIMENS

1. ARV Treatment: ○ First Dose of Treatment ○ Regimen Change ○ Repeat Script ○ Drug Substitution
(If Substitution answer Section C)

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

Regimen	Drug	Dose	Frequency	Duration	Comments
○ **Reg 1** (<3yrs)	Lamivudine (3TC)				
	Stavudine (D4T)				
	Kaletra				
○ **Reg 1** (>3yrs)	Lamivudine (3TC)				
	Stavudine (D4T)				
	Efavirenz (EFV)				
○ **Reg 2** (<3yrs)	Didanosine (ddl)				
	Zidovudine (AZT)				
	Efavirenz (EFV)/Nevirapine (NVP)				
○ **Reg 2** (>3yrs)	Didanosine (ddl)				
	Zidovudine (AZT)				
	Kaletra				

B. NON-ARV MEDICATION

Medication	Dose	Frequency	Duration	Comments
○ Cotrimoxazole (Bactrim)				
○ Fluconozole (Diflucan)				
○ MVTs				
○ Vitamin A				
○ Anthelminthic (Deworm)				
○ Other 1 *(specify):*				
○ Other 2 *(specify):*				

C. DRUG SUBSTITUTION *(Determined by nodal site)*

Drug	Dose	Frequency	Duration	Comments

Full Name of Prescriber: _____ **Qualification:** _____

Prescription Date: d d / m m / y y y y **Signature:** _____