FORM 6: PAEDIATRIC PATIENT FOLLOW-UP

(Form filled in by Doctor/Clinician)

Birth Registration/SA ID Number: | | | | | | | | | | | | | **Clinician:** | | | **Date of Visit:** d d / m m / y y y y

A. PRESENTING COMPLAINTS *(Information gathered through indirect questioning)*

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

Complaint/Symptom	Yes	Complaint/Symptom		Yes
Oral Sores	○	Abdominal Pains		○
Rash	○	Nausea/Vomiting		○
Cough	○	Dizziness		○
Fever	○	Other:		○
Diarrhoea	○	Other:		○
Headache	○	Other:		○

B. ILLNESSES

1. Has the patient visited a clinic or hospital since the last scheduled visit? ○ Yes ○ No

If Yes, give the reasons: _____

_____

2. If the patient been hospitalised since their last visit, what were the reasons? ○ OI ○ SBI ○ Other

If Other, give the reasons: _____

_____

C. 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
○ Caregiver Forgot
○ Felt too ill
○ Patient ran out of pills
○ Clinic ran out of medicine
○ Caregiver Status Change
○ Other *(Specify)* → _____

○ Yes ○ No

2. Does the patient or the Caregiver want to stop the taking of the patient's ARVs?

2a. If Yes, what are the reasons:

_____

_____

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)*

D. SOCIAL CIRCUMSTANCES

1. Has the patient moved since the last visit? ○ Yes ○ No

1a. If Yes, what is the new address: *(Physical Address or Directions)*

Area:

Postal Code:

District Code:

2. Has there been a change in the patient's Primary Caregiver? ○ Yes ○ No

2a. If Yes, what were the reasons for this change?

2b. If Yes, what is the new Caregiver's name?

Firstname:

Surname:

E. PHYSICAL EXAMINATION

Height ___ **cm**

Weight ___ . ___ **kgs**

BSA ___ . ___ **m^2**

$$\sqrt{\frac{kg \quad cm}{(Weight \times Height)}{3600}}$$

Temperature ___ . ___ **°C**

Head Circumference ___ . ___ **cm**

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

Comments:

F. TOXICITY MONITORING/ADVERSE EVENTS

Exclude intercurrent and non-ARV drug related cause of symptoms.

SYMPTOMS	YES	GRADE 1	2	3	4	COMMENTS/SPECIFY
Gastrointestinal	○	○	○	○	○	
Skin	○	○	○	○	○	
Nervous Systems	○	○	○	○	○	
LAB TEST	**YES**	**1**	**2**	**3**	**4**	**COMMENTS/SPECIFY**
Hb	○	○	○	○	○	
Lymphocyte	○	○	○	○	○	
ALT	○	○	○	○	○	
Other *(Specify other here)*	○	○	○	○	○	
Other *(Specify other here)*	○	○	○	○	○	

G. DEVELOPMENTAL MILESTONES

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

Examinations	Age	Normal	Static	Regressing	Comments
Gross Motor		○	○	○	
Fine Motor		○	○	○	
Language		○	○	○	
Social		○	○	○	
Scholasitc		○	○	○	

I. STAGING

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 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):		○	○	○	

K. LAB INVESTIGATIONS (To Order)

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

L. REFERRALS

Reason for Referral

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

M. 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 *(Refer to nodal site)* →
Name of Specialist Consulted:
Old Drug: New Drug:

○ Change Whole Regimen *(Refer to nodal site)* →
Name of Specialist Consulted:
New Regimen:

○ Treatment Interrupted → Reason:

○ Resume Treatment

○ Terminate Treatment → **Complete 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)*