KWAZULU NATAL DEPARTMENT OF HEALTH
COMPREHENSIVE CARE PROGRAMME

PAEDIATRIC FORMS TRAINING MANUAL

English Version 1.0
November 2004

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INTRODUCTION TO PAEDIATRIC PATIENT FORMS

The Paediatric Patient Forms are in a book format and each form has been printed in duplicate as two-part carbonless copies.

Some forms may appear lengthy - this is because they have been designed in such a way that the majority of the writing is done by simple answer selection and there is as little free-hand writing as possible.

Different forms have been designed for the collection of different types of patient information throughout the Patient Flow.
Each form specifies who is responsible for entering the information in that form (e.g. the admin clerk, the clinician, the counsellor, etc). Please note that this is intended as a general guideline as this could vary depending on the ARV programme operation at your site.

The definition of a paediatric patient is a child less that or equal to 14 years of age.

Instructions to follow when completing the Paediatric Patient Forms:

- Press firmly when writing on a form to ensure that whatever is entered on the top page is transcribed into the bottom page.
- Ensure that you use a page separator to prevent the transfer of marks onto other pages of the form booklet.
- It is preferable to use CAPITAL LETTERS.
- Please write clearly and ensure that your answer selection is well marked.
- Please completely darken (fill-in) the ‘o’ bubbles when selecting your options.
- Please write one letter or digit in each block when blocks are provided.
- If you do not have an answer or relevant response to a question, you should leave the answer block BLANK
- Please do not leave spaces or use dashes when entering contact numbers
  e.g. to enter 0317656398 is correct
  to enter 031-765 6398 is incorrect
- Please put a cross or line through incorrect answers and write the correct answer, as clearly as possible, next to the answer box provided.

OVERVIEW OF FORM FLOW

FORM 1 Paediatric Patient Registration Form

FORM 2 Paediatric Baseline Clinical Examination Form

FORM 3 Paediatric Patient Counselling Form

FORM 4 Paediatric Baseline Laboratory Results Form

FORM 5 Paediatric Prescription Form

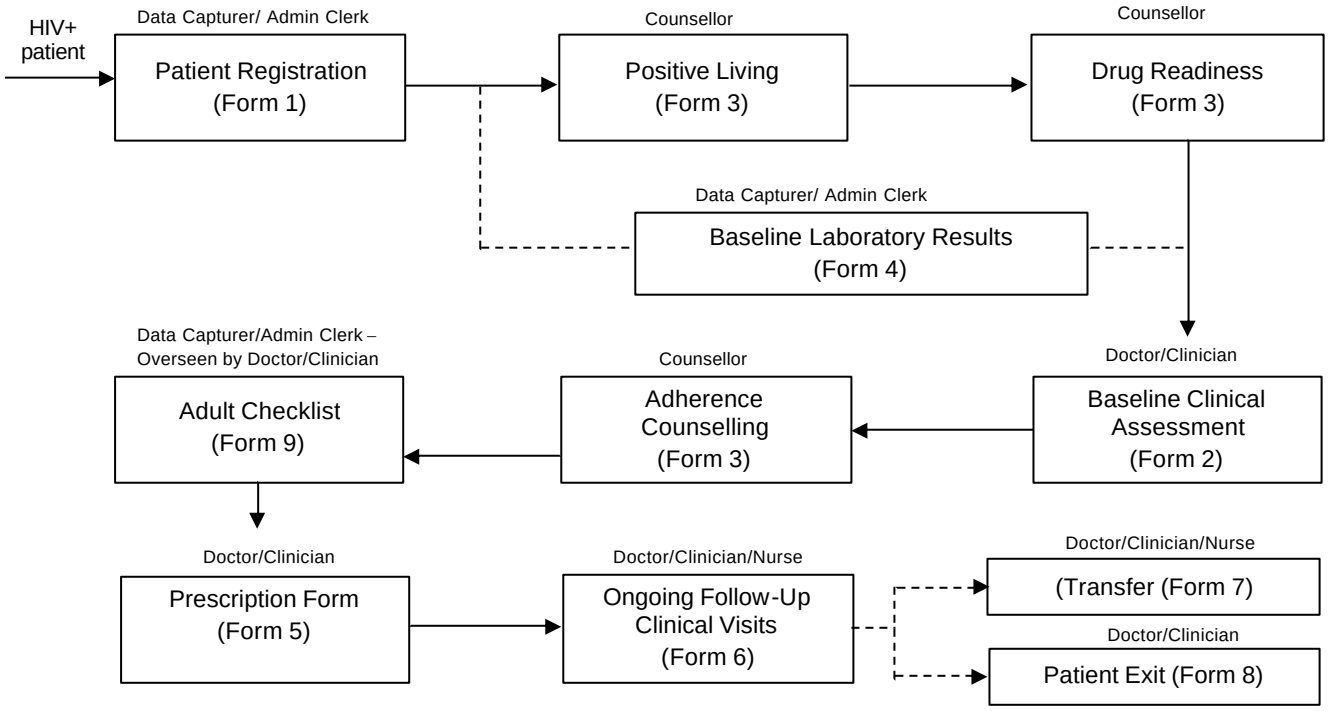
FORM 6 Paediatric Patient Follow-Up Form

FORM 7 Paediatric Inter-Hospital Transfer Form

FORM 8 Paediatric Patient Exit Form

FORM 9 Paediatric Checklist Form

Paediatric Visit Summary Form

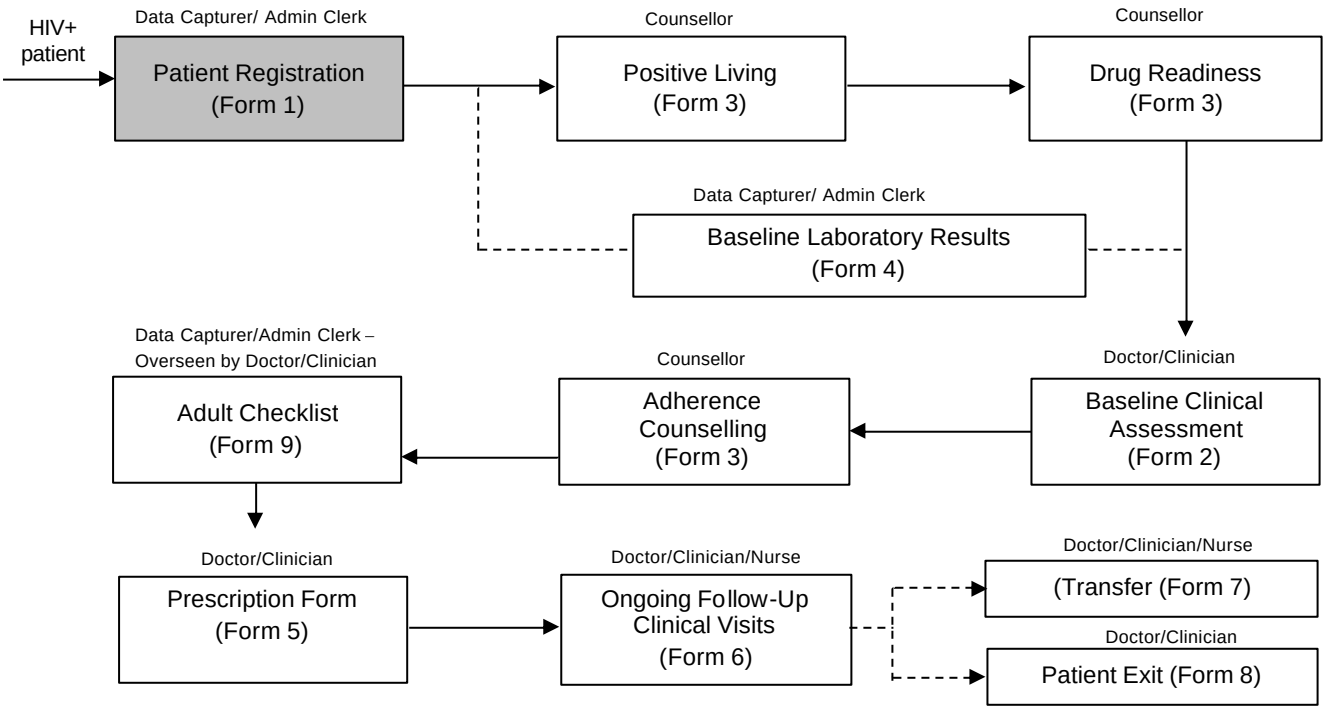


1. FORM 1: PAEDIATRIC PATIENT REGISTRATION

The PAEDIATRIC PATIENT INFORMATION FORM (FORM 1) contains all the ESSENTIAL PATIENT AND PRIMARY CARE GIVER INFORMATION.

This form is THREE pages in length and is completed by the Admin Clerk or Data Capturer.

Please ensure that the PATIENTS BIRTH REGISTRATION NUMBER and NAME is entered exactly as it is reflected on the Patient's Birth Certificate.



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FORM 1: PAEDIATRIC PATIENT REGISTRATION

(Form filled in by Clerk/Data Capturer)

Birth Registration/SA ID Number:

NL = KwaZulu

Province: N L

Registration Date: y y y

Must have patient's birth certificate in order to be registered. Birth registration number is ALWAYS 13 digits

For use if the Hospital has a File number system (if patient has a file number)

Patient Surname:

Middle Names:

Hospital File Number: *(if relevant)*

Site Code:

Capturer:

Each site has its own 3 letter site

First letter of Capturer's first name and first two letters of last name.
Eg. Eunice Gumede: EGU

Funding/Billing: ○ Government ○ Private/Other *(Specify):*

A. DETAILS OF GUARDIAN

The guardian is the person legally responsible for the patient. The guardian is not always the primary caregiver

Guardian Firstname:

Guardian Surname:

1. Is the Guardian the Primary Caregiver? ○ Yes ○ No

2. What is the Guardian's relationship to the patient? *(Fill all that apply)*

○ Parent ○ Household Member ○ Other *(Specify)*

○ Family Member ○ Foster/Surrogate Parent

B. DETAILS OF PRIMARY CAREGIVER *(Person responsible for bringing the child to the hospital)*

Firstname: *(If Primary Caregiver is different from the Guardian)*

Surname: *(If Primary Caregiver is different from the Guardian)*

The primary caregiver is the person who looks after the patient on a daily basis

1. Home Language: ○ Zulu ○ Xhosa ○ Other *(Specify)*

2. English Ability: *(Fill all that apply)* ○ Understa ○ Read ○ No English Ability

C. PATIENT DETAILS

1. Date of Birth: d d / m m / y y y y

This is as per the patient's birth certificate

2. Gender: ○ Male ○ Female

3. Population Group: ○ Black ○ Coloured ○ Indian ○ White ○ Other *(Specify)*

4. Home Language: ○ Zulu ○ Xhosa ○ Sotho ○ English ○ Afrikaans ○ Other *(Specify)*

5. Referred By: ○ VCT Site ○ Self-Referral ○ Inpatient ○ Traditional Healer ○ PMTCT Site ○ TB Clinic ○ Outpatient ○ Other *(Specify)*

6. Parents: ○ Alive ○ Deceased

6a. If Deceased, specify which parents: ○ Mother ○ Father ○ Both Parents

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C. CONTACT DETAILS

1. Patient's Primary Address: *(Physical Address or Directions)*

The home where the patient lives (or mostly stays at). If there is no physical address, give specific directions on how to get there, You will need to WRITE SMALL

Area:

Postal Code:

District Code:

Four Letter Code for each District

2. Telephonic Details of Primary Caregiver:

(Only enter numbers - no brackets or dashes)

l (home):

el (work):

D. ALTERNATIVE ADDRESS

1. Does the patient have another address that is visited regularly? ○ Yes ○ No

1a. If so, when does the patient go?

○ Monthly ○ Twice a year ○ Quarterly

○ Other *(Specify)*

We need to ascertain if the patient visits another address on a regular basis (e.g. visits family at the farm for regular extended periods

1b. How long does the patie

○ Less than a month

○ More than a month *(Specify)* →

1c. Directions to the alternative address:

Give detailed instructions to find the address, especially in a rural area where no street names are available (e.g. turn left at green Telkom container, past Spaza shop…etc)

Important information to ensure sufficient treatment available during these visits away from home

E. ALTERNATIVE CONTACT PERSON *(Other than that of the Child's Guardian)*

Who is the patient's alternative contact person/next of kin?

Name:

Address:

Person who would be contacted if the primary caregiver is reachable

Area:

Postal Code **District Code**

Telephone:

What is the patient's relationship to this person:

○ Mother
○ Father
○ Family Member
○ Household Member
○ Friend
○ Health Care Provider
○ Other *(Specify)*

HIV status disclosed to this person? ○ Yes ○ No

A patient may have walked for 30km and then taken a taxi. This influences the quality of time it took. Fill in all options that apply for the trip from home to the hospital

F. TRAVEL AND DISTANCE

1. How long does it take for you to come from home to the hospital:

○ Less than 30mins ○ 30mins to 1hr ○ 1hr to 2hrs ○ More than 2hrs

1a. What will be your usual means of coming to the hospital: ○ Bus ○ Car ○ Taxi ○ Train ○ Walk
(Fill all that apply)

1b. What is the name of the nearest clinic to where you live:

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G. SOCIAL SECURITY GRANTS

1. Are you (the Guardian) the recipient of a Social Security Grant(s)? ○ Yes ○ No ○ Applied *(If in doubt refer to a social worker - Question 4b)*

1a. If Yes, what type of Grant(s) do you receive?

○ Old Age Grant ○ Care Dependency Grant

○ Disability Grant ○ Child Support Grant → ☐☐ *(Specify for how many children)*

○ Social Relief of Distress Grant ○ Foster Care Grant → ☐☐ *(Specify for how many children)*

1b. Refer to a social worker? ○ Yes ○ No *(For Grant Application/Home Affair Assistance)*

If uncertain if patient qualifies for any grants – refer to Social worker

H. DOMESTIC FACILITES

1. What type of Water Supply do you have in your home? ○ Piped Water in Home ○ Communal Tap ○ Surface Water

2. What type of Sanitation do you have at home? ○ Flushing Toilet ○ VIP *(Non-Flushing Outside Toilet)*

3. Do you have Electricity in your home? ○ Yes ○ No

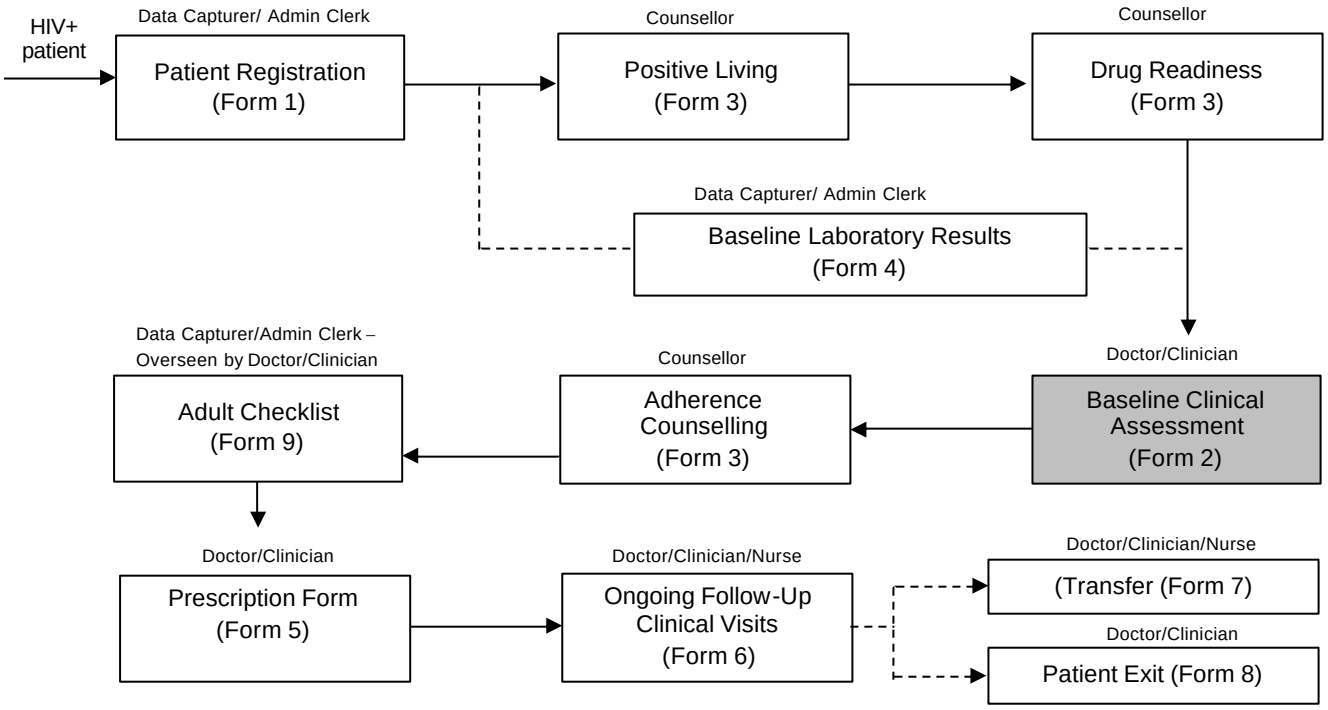
4. What kind of Cooking Facilities do you use at home? ○ Wood ○ Gas ○ Paraffin ○ Electrical Stove

Comments:

2. FORM 2: PAEDIATRIC BASELINE CLINICAL EXAMINATION

The PAEDIATRIC BASELINE CLINICAL EXAMINATION FORM (FORM 2) contains the information collected during the patient's baseline examination performed by the doctor.

This form is FOUR pages in length and is completed by the Clinician / Doctor.



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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:

If any of the options in 'Section A' are selected then the patient MUST be referred to a specialist site

Indicate by ticking 'Specialist Site' option in the referral section on page 4 of this form

B. HOSPITALISATION

1. Has the patient been hospitalised within the last year? ○ Yes ○ No

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

Reason	How Long
1]	
2]	
3]	
4]	

This includes any reason for hospitalisation in the last year

C. MEDICATION

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

Medication		Current Use	Comments
Cotrimoxazole (Bactrim)		○ Yes ○ Unknown	
Fluconozole (Diflucan)		○ Yes ○ Unknown	
Traditional Medicine		○ Yes ○ Unknown	
Nutritional Supplements:	MVTs	○ Yes ○ Unknown	
	Other	○ Yes ○ Unknown	*Specify:*
Other 1 *(specify):*		○ Yes ○ Unknown	
Other 2 *(specify):*			

Multi Vitamins

State the name of the Nutritional Supplement

State the name of the Medication

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 d**

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

Indicate by ticking 'Dietician' in the referral option on page 4 of this form

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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

If only the month and year are known then type the digits '99' for the day

○ Yes *(Specify)* →

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

BSA = Body Surface Area

E. PHYSICAL EXAMINATION

Height ___ cm

Weight ___.___ kgs

BSA ___.___ m^2

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

BSA calculation

Temperature ___.___ °C

Head Circumference ___.___ cm

14,5 kg's is entered as 014.5 kgs

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

Comments:

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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:

WHO = World Heath Organisation

H. STAGING

1. What is the patient's WHO Stage:

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

Comments:

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

Traditional Medicine MUST be discontinued

Multi Vitamins

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):*

This is not the actual order form for lab investigations, but rather specifies which test were/need to be ordered via the hospital's existing system.

This is for information purposes ONLY

Tick to indicate which lab investigations have been ordered via your normal hospital lab system

K. REFERRALS

Reason for Referral

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

Select all the referrals that are required for the patient as determined during this in the Baseline Clinical Examination

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)*

Form 2: Paediatric Baseline Clinical Examination
Page 4 of 4

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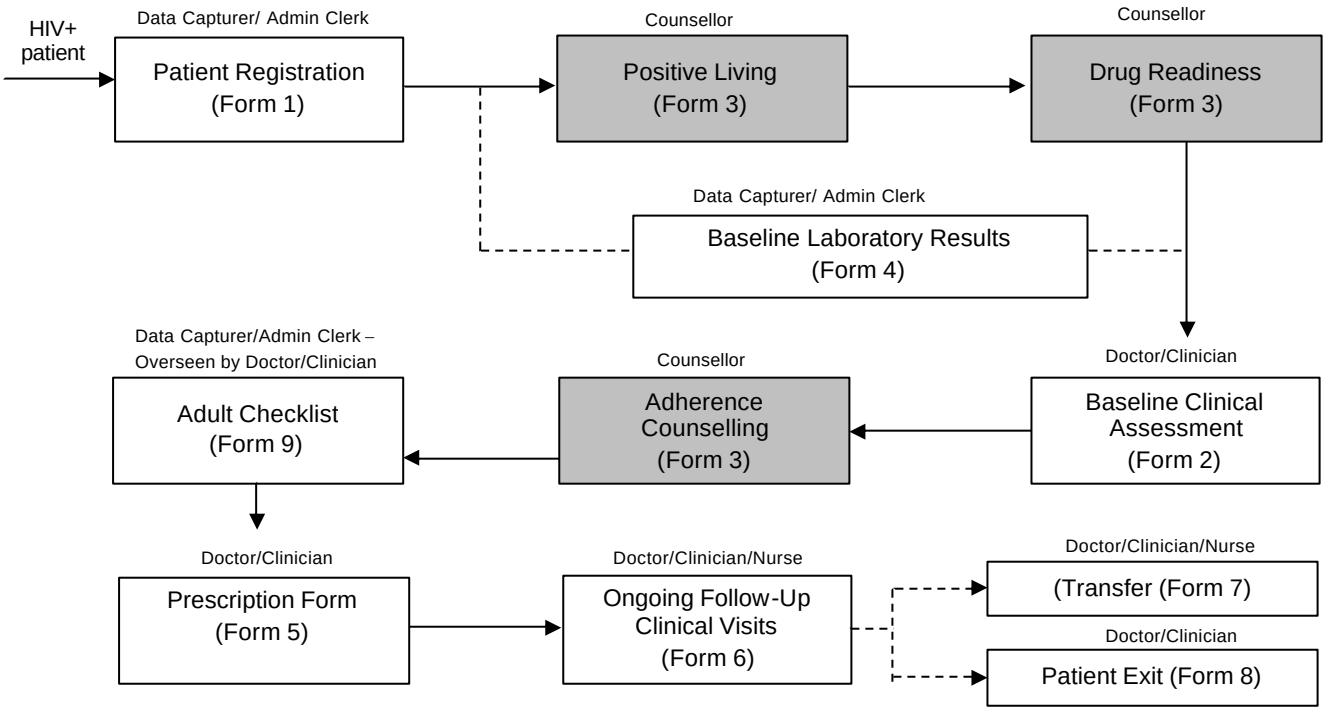
3. FORM 3: PAEDIATRIC PATIENT COUNSELLING FORM

The PAEDIATRIC PATIENT COUNSELLING (FORM 3) contains the information regarding the training courses the primary care giver and the patient has attended; and information regarding the people the primary care giver and/or patient has disclosed his/her HIV status to.

This form is ONE page in length and is completed by the Counsellor.



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FORM 3: PAEDIATRIC PATIENT COUNSELLING FORM

(Form filled in by Counsellor)

Birth Registration/SA ID Number:

Capturer: **Counsellor**

d d / m m / y y y y

Enter the date this training course was attended by the primary caregiver and the patient

A. GROUP COUNSELLING SE

Positive Living

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	O Yes O No	d d / m m / y y y y	

Counsellor's name / initials

Drug Readiness

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	O Yes O No	d d / m m / y y y y	

Drug Adherence

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	O Yes O No	d d / m m / y y y y	

Nutritional Assessment

Due Date	Counsellor
d d / m m / y y y	

Specify any other treatment training course attended by the caregiver and/or the patient at your site.

Specify any training courses repeated by the caregiver and the patient

Other Patient Training *(Specify)* →

Due Date	Attend	Date Attended	Counsellor
d d / m m / y y y y	O Yes O No	d d / m m / y y y y	

B. DISCLOSURE

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

O Parent(s) O Household Member O Other (1) *(Specify)*

O Family Member O Health Care Worker O Other (2) *(Specify)*

2. Is the patient aware of their HIV Diagnosis? O Yes O 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?

Form 3: Paediatric Patient Counselling Form
Page 1 of 1

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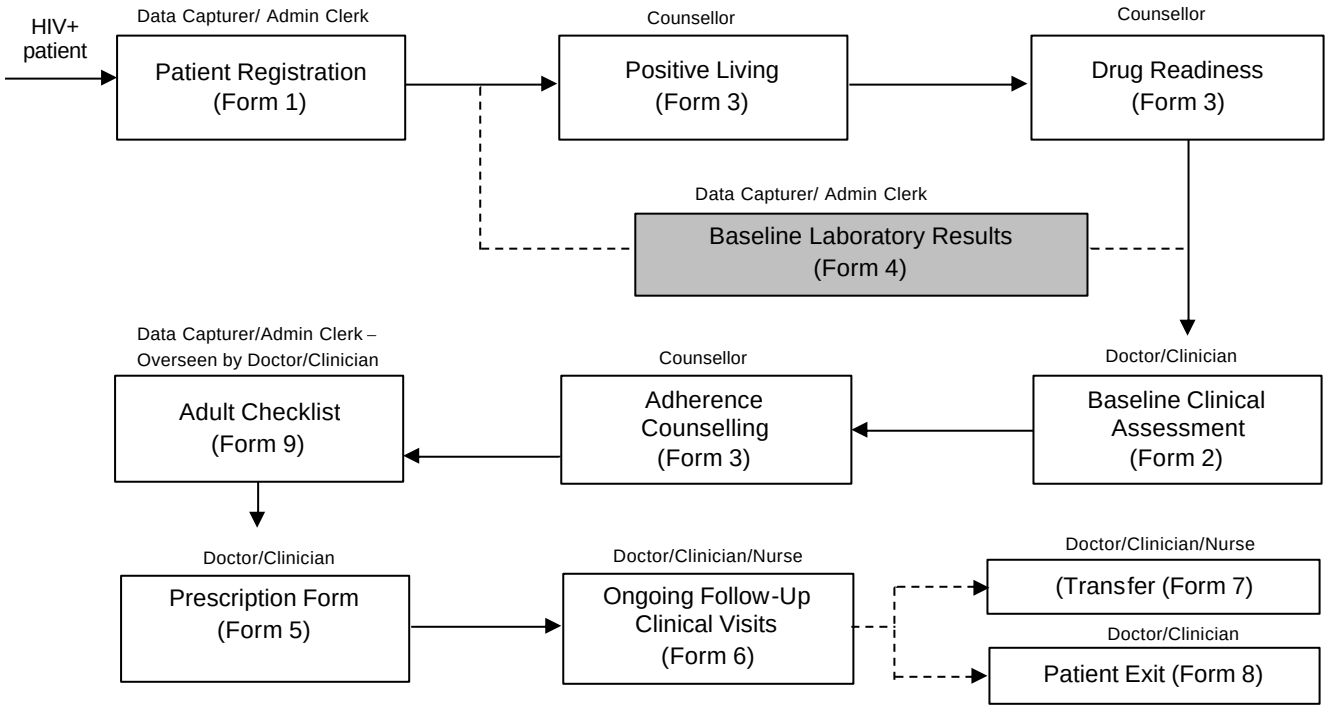
4. FORM 4: PAEDIATRIC BASELINE LABORATORY RESULTS

The PAEDIATRIC BASELINE LABORATORY FORM (FORM 4) contains the information regarding all tests requested by the clinician as well as the results of these tests.

PLEASE NOTE this form is not the order form itself. All tests requested by the clinician must be processed via the hospital's existing laboratory test ordering mechanism (i.e. complete necessary paper work). Once these test results are received back from the lab, the admin clerk or data capturer is then responsible for recording them on this data collection form.

This form is ONE page in length and is completed by the Admin Clerk / Data Capturer.



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FORM 4: PAEDIATRIC BASELINE LABORATORY RESULTS

(Form filled

Birth Registration/SA ID Number:

oods Taken: m m / y y y y

The Clinician must select the test/s that he/she has ordered via the hospitals ordering system.

The Data Capturer is then able to see which test/s results are outstanding from the lab

A. HIV TEST

Type of Test: ○ Elisa ○ PCR

Date Tested: d d / m m / y y y y

Laboratory Site:

B. CD4 RESULT

○ **CD4%:** . **Date Tested:** d d / m m / y y y y

Laboratory Sit

Once the test result is received from the lab, the data capturer is responsible for entering the result from the lab system onto this form

C. HAEMATOLOGY

○ **Lymphocyte** . 10^9/L

○ **Haemoglobin** . g/dl

○ **Platelets** 10^9/L

D. CHEMICAL PATHOLOGY

○ **Amylase** . IU/L

○ **Cholestrol** . mmol/L

○ **Glucose** . mmol/L

○ **Triglycerides** . mmol/L

E. LIVER FUNCTION TESTS

○ **ALT** . IU/L

F. TURBERCULOSIS

○ **TB Skin Test:** ○ Positive ○ Negative

○ **AFB:** ○ Positive ○ Negative

○ **Chest X-Ray:** ○ Normal ○ Abnormal

G. VIROLOGY

○ **Viral Load:** copies/ml

Viral Load Log: .

Date Tested: d d / m m / y y y y

Laboratory Site:

H. OTHER TESTS

	Other Tests:	Date Tested:	Result:
1] ○	**Hepatitis B** *(Optional)*	d d / m m / y y y y	○ Positive ○ Negative
2] ○		d d / m m / y y y y	
3] ○		d	
4] ○		d d / m m / y y y y	

Specify any other test ordered for the patie nt

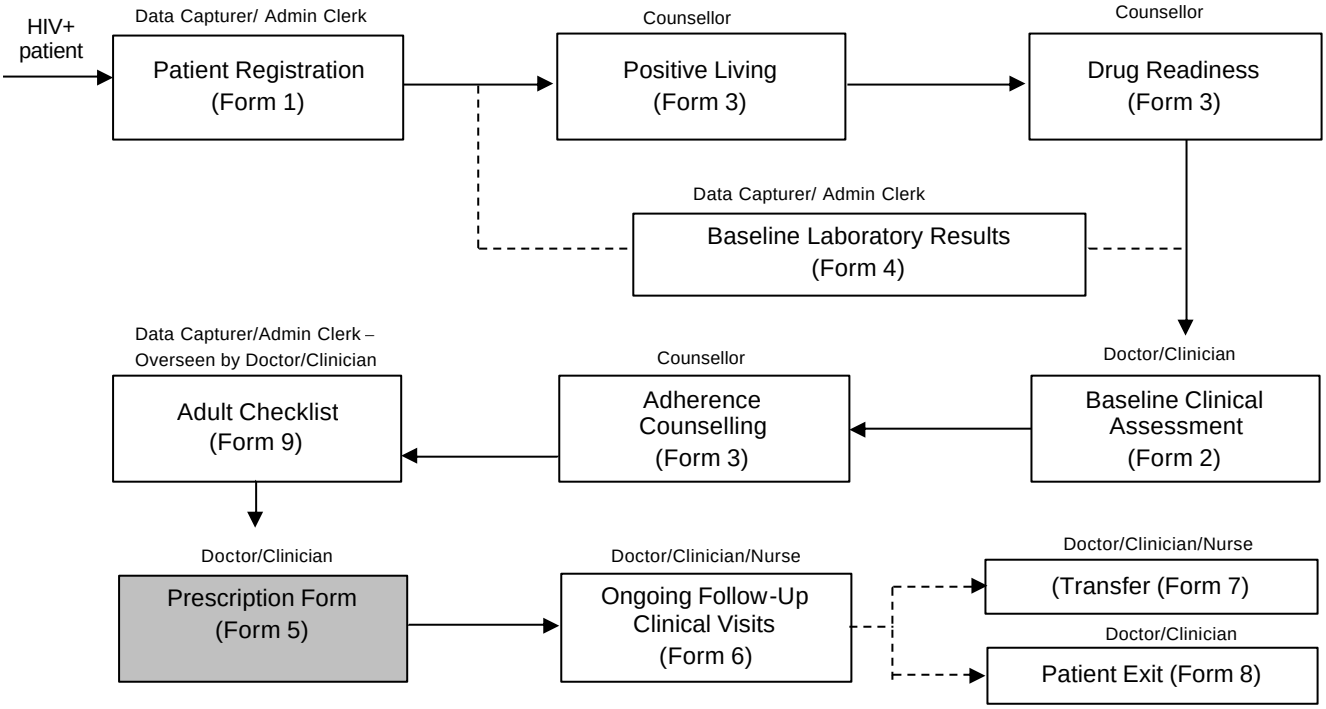
Comments:

5. FORM 5: PAEDIATRIC PRESCRIPTION FORM

The PAEDIATRIC PRESCRIPTION FORM (FORM 5) is the form used for the initiation of the patient's ARV treatment. It is also used to indicate repeat prescription, regimen changes and drug substitutions.

This is the PRESCRIPTION FORM the Clinician uses to ORDER the medication.

This form is ONE page in length and is completed by the Clinician.



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FORM 5: PAEDIATRIC PRESCRIPTION FORM

(Form filled in by Doctor)

This is the PRESCRIPTION FORM the Clinician uses to ORDER the medication.

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

List all the drugs that make up the modified regimen

Full Name of Prescriber: **Qualification:**

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

Form 5: Paediatric Prescription Form
Page 1 of 1

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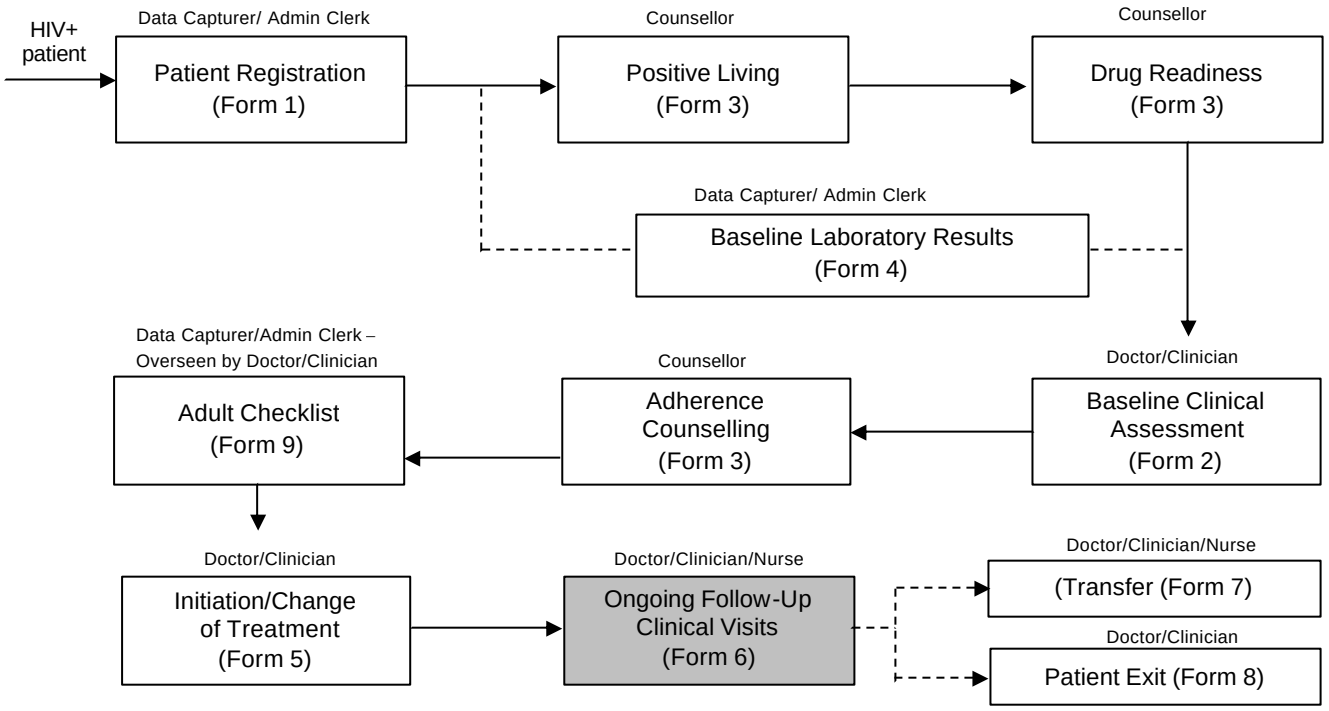
6. FORM 6: PAEDIATRIC PATIENT FOLLOW-UP

The PAEDIATRIC PATIENT FOLLOW-UP FORM (FORM 6) is the form used for all follow-up clinical examinations once the patient has started ARV treatment.

This form is FOUR pages in length and is completed by the Clinician.



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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:	

Please specify any other symptom or sign the patient is experiencing since their last visit

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 l… …asons? ○ OI ○ SBI ○ Other

If Other, give the reasons: _____

_____

This is a critical section which is followed up by the Counsellor.

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 ○ ARV Site ran out of medicine

○ Caregiver Forgot ○ Caregiver Status Change

○ Felt too ill ○ Other *(Specify)*

○ Patient ran out of pills

○ 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:

_____

_____

See section M on page 4 of this form to indicate referral to Adherence Team.

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)*

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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:

BSA = Body Surface Area

E. PHYSICAL EXAMINATION

Height ___ **cm**

Weight ___ . ___ **kgs**

BSA ___ . ___ **m^2**

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

BSA calculation

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:

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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**	
Hb	○	○	○	○	○	
Lymphocyte	○	○	○	○	○	
ALT	○	○	○	○	○	
Other *(Specify other here)*	○	○	○	○	○	
Other *(Specify other here)*	○	○	○	○	○	

Please indicate the severity of the symptom experienced by the patient by entering the respective grade

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

Enter the patient's current World Health Organisation 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 which are to be ordered and which are to be changed:

Medication		Recommendation Start	Stop	Continue	
Cotrimoxazole (Bactrim)		○	○	○	
Fluconozole (Diflucan)		○	○	○	
Traditional Medicine		☒	○	☒	
Nutritional Supplements:	MVTs	○	○	○	
	Other	○	○	○	Specify:
Vitamin A		○	○	○	
Anthelminthic (Deworm)		○	○	○	
Other 1 (specify):		○	○	○	
Other 2 (specify):		○	○	○	

If there ARE ANY CHANGES to the non-ARV medication please specify below

All traditional medication to the DISCONTINUED

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K. LAB INVESTIGATIONS (To Order)

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

This is not an order for lab investigations.

This is for information purposes ONLY

Tick to indicate which lab investigations have been ordered for this patient via your normal hospital lab investigation system

L. REFERRALS

Reason for Referral

- ○ Social Work
- ○ Counselling
- ○ Other *(Specify name and reason)* →

Select all the referrals that are required for the patient as determined during this in the Follow-up Examination

M. ARV TREATMENT SUMMARY/ACTION

Has the patients health remained the same, improved or deteriorated since the last examination

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:

Specify the name of the Specialist Consulted who authorised the drug substitution

- ○ 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)

Indicate if this is a change to the whole Regimen.

Specify the name of the Specialist Consulted to authorise the whole regimen change

Comments:

If treatment is terminated then an EXIT form (Form 8) MUST be completed

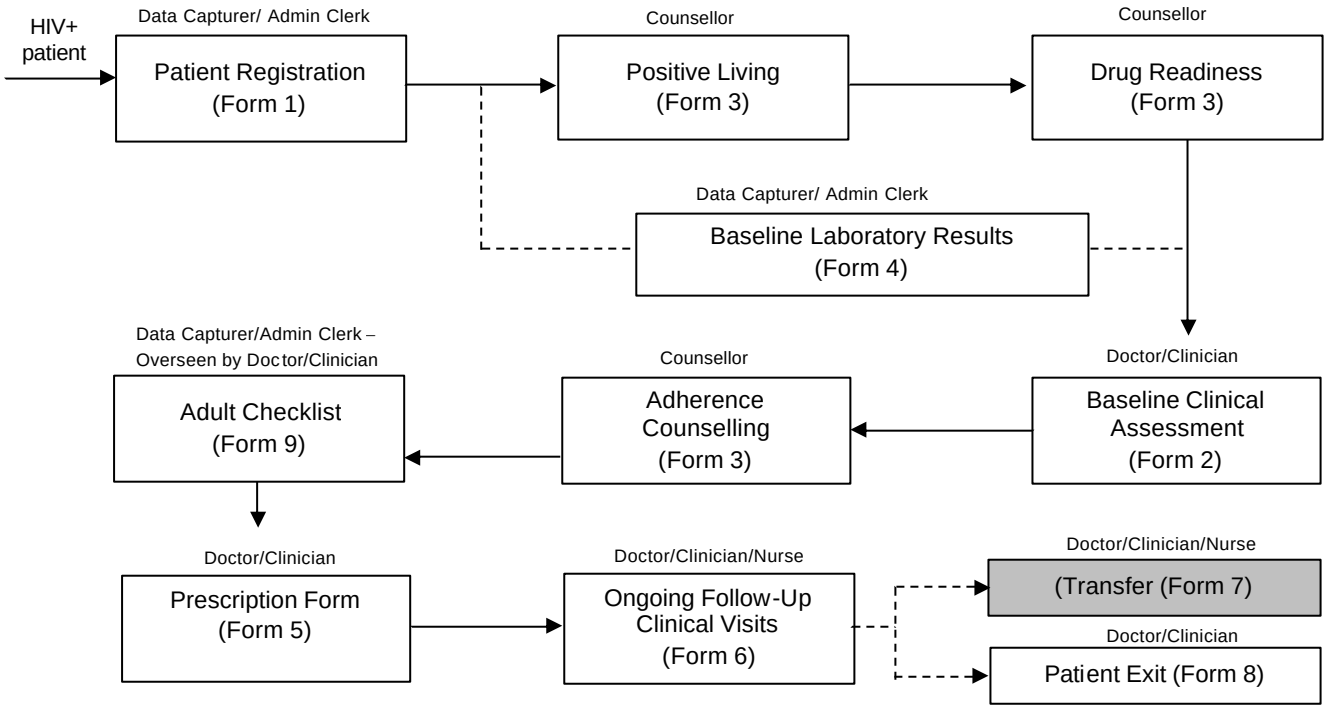
Next Appointment Date: d d / m m / y y y y **Time:** h h : m m *(24 hrs - eg. 13:30)*

7. FORM 7: PAEDIATRIC INTER-HOSPITAL TRANSFER FORM

The PAEDIATRIC INTER-HOSPITAL TRANSFER FORM (FORM 7) is the form used when a patient is transferring out of the ARV treatment programme at your site and will be transferring into the ARV treatment programme at another South African Government site.

This form is for information purposes only (to track patient movement).

This form is ONE page in length and is completed by the Admin Clerk / Data Capturer.



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FORM 7: PAEDIATRIC INTER-HOSPITAL TRANSFER FORM

(Form filled in by Clerk/Data Capturer)

Transfer To: *(Name of new Treatment Site)*

Date of Transfer: d d / m m / y y y y

Site Code:

Province: ○ NL ○ EC ○ FS ○ GT ○ LP ○ MP ○ NC ○ NW ○ WC

District Code:

Telephone:

Fax:

Transfer From: *(Name of transfering Treatment Site)*

Site Code:

Province: N L

Capturer:

District Code:

Telephone:

Fax:

A. PATIENT DETAILS

Birth Registration/SA IDNumber:

Telephone/Cell:

Patient Firstname:

Patient Surname:

B. PRIMARY CAREGIVER INFORMATION

Firstname:

Tel (home):

Surname:

Tel (work):

C. REASON FOR TRANSFER

1. Please specify the reason for the transfer: ○ Closer Site ○ Change in Residential Address ○ Other

(If Other, Specify Reason)

(This section is filled in by the Site receiving the patient)

Has the first appointment been made: ○ Yes ○ No *If Yes, when* d d / m m / y y y y

Date of receipt of Transfer Form: d d / m m / y y y y

Please fax/mail this section when completed to:

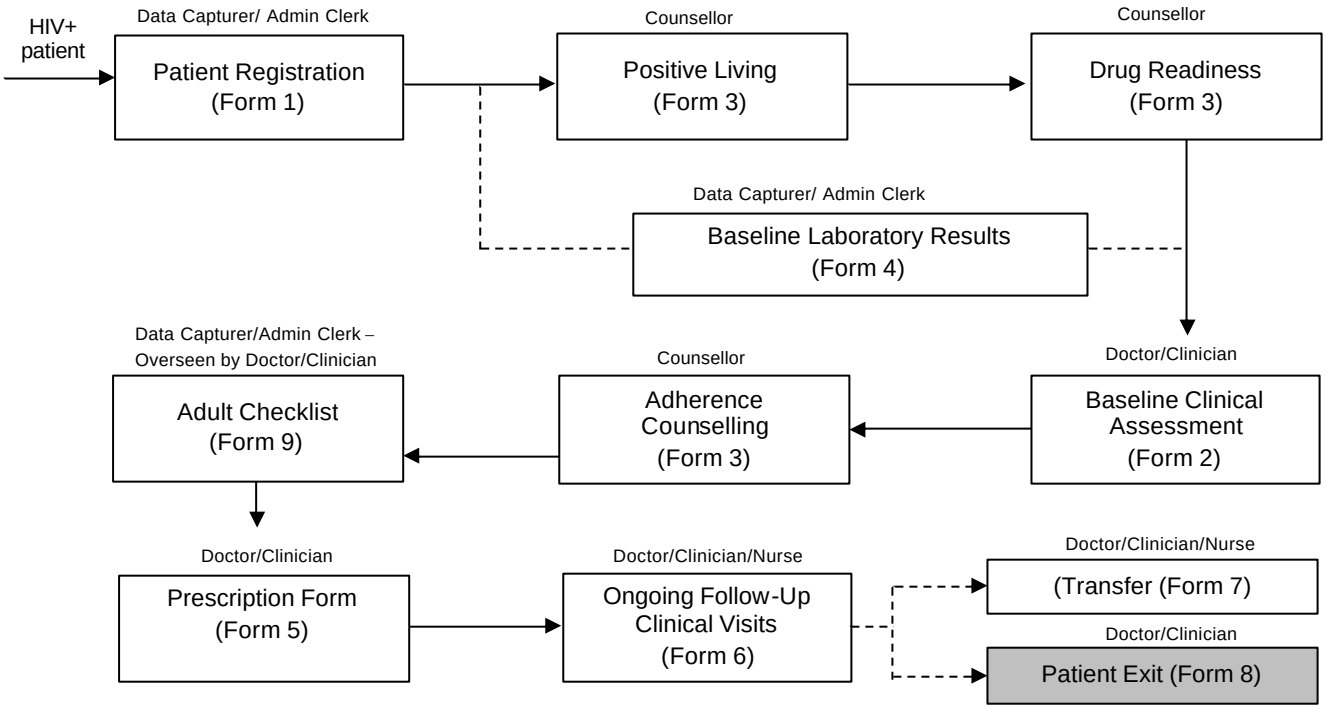
(Only enter numbers - No brackets or dashes)

Patient has attended first visit at new ART site: ○ Yes ○ No

8. FORM 8: PAEDIATRIC PATIENT EXIT FORM

The PAEDIATRIC PATIENT EXIT FORM (FORM 8) is the form used when a patient is EXITING the ARV treatment programme.

This form is ONE page in length and is completed by the Counsellor.



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FORM 8: PAEDIATRIC PATIENT EXIT FORM

(Form filled in by Counsellor)

Birth Registration/SA ID Number: | | | | | | | | | | | | | **Capturer:** | | | **Exit Date:** d d / m m / y y y y

A. REASONS FOR EXITING THE PROGRAMME

Please specify the reason for discontinuation from the programme:

- ○ Patient Request *(Request - complete Section 1)*
- ○ Caregiver Request
- ○ Patient Defaulted *(Defaulted - complete Section 2)*
- ○ Caregiver Defaulted
- ○ Patient Deceased *(Deceased - complete Section 3)*

Please specify the reason for the patient discontinuing the programme

1. Request to discontinue with the programme

1a. Date of Discontinuation: d d / m m / y y y y

1b. What were the reasons: _____

Please give as much detail as possible to describe the reason the patient requested to discontinue with the programme

2. Patient known/reported to be deceased

2a. Date of Death: d d / m m / y y y y

2b. Cause of death known: ○ Yes ○ No

If Yes, what was the cause: _____

2c. Source of Information:

○ Death Certificate ○ Friend/Relative ○ Hospital Records ○ Other *(Specify)* _____

3. Defaulted

3a. Default Date: d d / m m / y y y y

3b. Please specify the contributory factors for Defaulting:

Factor	Not coping	Disinterested	Deceased	Too sick	Comments
Parent	○	○	○	○	
Caretaker	○	○	○	○	
Child	○	○	○	○	

3c. Source of Information:

○ Patient ○ Caregiver ○ Friend/Relative ○ Other *(Specify):* _____

Form 8: Paediatric Patient Exit Form
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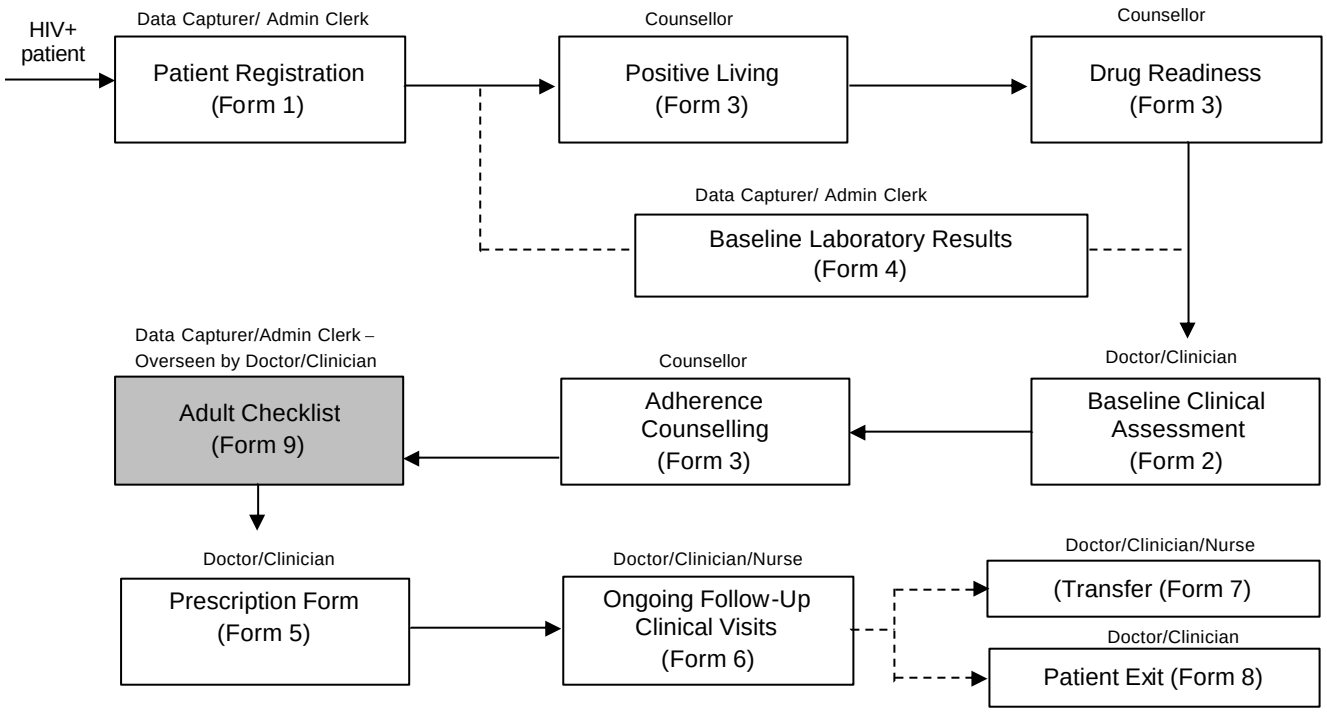
9. FORM 9: PAEDIATRIC CHECKLIST

The PAEDIATRIC PATIENT CHECKLIST is the form used to record all the actions necessary before a patient can be determined 'drug ready' (i.e. ready to begin ARV treatment).

This is a ONE page checklist and is updated by the Admin Clerk / Data Capturer.



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FORM 9: PAEDIATRIC CHECKLIST

(Form filled in by Clerk/Data Capturer and Clinician)

Birth Registration/SA ID No: | Clinician: | Checki: d d

Each action must be answered with YES or NO

If the reply to an action is YES - please specify the date of the action and complete any required comments

ACTION	DONE	DATE	COMMENTS
Patient Registered	○ Yes ○ No	d d / m m / y y y y	
CD4% Taken	○ Yes ○ No	d d / m m / y y y y	. %
WHO Staging	○ Yes ○ No	d d / m m / y y y y	WHO Stage *(Circle all that apply)*
Non-ARV Medicine Prescribed	○ Yes ○ No	d d / m m / y y y y	MVTs / Vit A / Worm / Bactrim
HIV Status Disclosed			
- To Family *(Family must be Yes)*	○ Yes ○ No	d d /	
- To Child *(If child is >12yrs then Yes)*	○ Yes ○ No	d d /	
Primary Caregiver	○ Yes	d d / m m / y y y y	
Positive Living	○ Yes ○ No	d d / m m / y y y y	
Drug Readiness	○ Yes ○ No	d d / m m / y y y y	
Drug Adh		d d / m m / y y y y	
Baseline B		d d / m m / y y y y	
Nutritional Assessment	○ Yes ○ N	d d / m m / y y y y	Supplements: ○ Yes ○ No
Caregiver Knowledge	1. Drug Names: ○ Yes ○ No	2. Drug Doses: ○ Yes ○ No	
TB Excluded	○ Yes ○ No		
If No, TB treated for more than 2 months:	○ Yes ○ No	d d / m m / y y y y	
Drug Ready	○ Yes ○ No	d d /	
ARV Start Date		d d / m	Regimen Number:

Has the caregiver and the patient attended the 'Positive Living' , 'Drug Readiness' and 'Drug Adherence' training courses?

Does the caregiver know the drug names and doses the patient is taking?

The Clinician has ascertained that the patient does not have TB

If the patient has TB, have they been on TB treatment for more than 2 months

Is the patient ready to begin treatment?

Form 9: Paediatric Checklist
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10. PAEDIATRIC VISIT SUMMARY FORM

The PAEDIATRIC VISIT SUMMARY is the summary that is located at the front of the patients file. The information in this summary is updated every visit. It gives the Clinician a one-page view of the past five visits showing the patient's vital information that helps to indicate if the patient has improved or deteriorated during the last month.

This is a one-page view summary that rolls-on to a new sheet once the current page is full. There is therefore a history from date of registration to track the patients health.

This visit summary is updated by the Admin Clerk / Data Capturer.

Birth Registration/SAID Number

Hospital File Number

Treatment Start Date

PAEDIATRIC VISIT SUMMARY FORM

KwaZulu Natal Department of Health
Comprehensive Care Programme

Date of Visit		/ /		/ /		/ /		/ /		/ /	
Age											
WHO Staging											
Height (cm)											
% Expected Height											
Weight (kgs)											
% Expected Weight											
Head Circumference (cm)											
BSA											
Development (Normal/Static/Regressive)		N / S / R		N / S / R		N / S / R		N / S / R		N / S / R	
TB Symptoms (Tick=Yes)											
Months on TB Treatment											
Problems since last visit	1										
	2										
	3										
	4										
Bloods Taken (X=No; Tick=Yes)											
Blood Results	CD4%										
	Viral Load										
	Hb										
	Lymphocyte										
	Plts										
	ALT										
	Glucose										
	Triglycerides										
	Cholestrol										
Other Tests	Test Type										
	Result										
Treatment Regimen											
Months on Regimen											
Change in Treatment Regimen											
No. of Missed Doses											
Adverse Events/ Side Effects	Event / Grade										
	Event / Grade										
	Event / Grade										
Non-ART Medication	MVTs / Vit A / Worm										
	Bactrim										
	Fluconazole										
Referrals (Tick=Yes)	Social Work										
	Counselling										
	Other *(specify)*										
Social	Change in Address										
	Change in Caregiver										
	Grants										
Action											
Comments											
Captured By											