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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

HIV+ patient

Data Capturer/ Admin Clerk

Patient Registration
(Form 1)

Positive Living
(Form 3)

Drug Readiness
(Form 3)

Baseline Laboratory Results
(Form 4)

Adult Checklist
(Form 9)

Adherence Counselling
(Form 3)

Baseline Clinical Assessment
(Form 2)

Prescription Form
(Form 5)

Ongoing Follow-Up Clinical Visits
(Form 6)

Doctor/Clinician/Nurse

Patient Exit (Form 8)

Doctor/Clinician/Nurse

Data Capturer/ Admin Clerk – Overseen by Doctor/Clinician

Doctor/Clinician

Data Capturer/ Admin Clerk
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.
**Form 1: Paediatric Patient Registration**

**A. DETAILS OF GUARDIAN**

- **Guardian Firstname:**
- **Guardian Surname:**

1. **Is the Guardian the Primary Caregiver?**
   - Yes
   - No

2. **What is the Guardian's relationship to the patient?**
   - Parent
   - Household Member
   - Family Member
   - Foster/Surrogate Parent
   - Other (Specify)

**B. DETAILS OF PRIMARY CAREGIVER**

- **Firstname:**
- **Surname:**

1. **Home Language:**
   - Zulu
   - Xhosa
   - Sotho
   - English
   - Afrikaans
   - Other (Specify)

2. **English Ability:**
   - Understand
   - Speak Little
   - Speak Well
   - Read
   - No English Ability
   - Other (Specify)

**C. PATIENT DETAILS**

1. **Date of Birth:**
   - Day
   - Month
   - Year

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

2. Telephonic Details of Primary Caregiver:
   (Only enter numbers - no brackets or dashes)
   Tel (home): ________________________
   Tel (work): ________________________
   Tel (cell): ________________________

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  Quarterly  Other  (Specify)
   1b. How long does the patient go for?
       Monthly  Quarterly  Twice a year  Annually  Other  (Specify)
       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)

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: ____________________________
   Area: ____________________________
   Postal Code: ______________________
   District Code: ____________________
   Telephone: ________________________

   Who is the patient's alternative contact person/next of kin?
   Name: ____________________________
   Address: ____________________________
   Area: ____________________________
   Postal Code: ______________________
   District Code: ____________________
   Telephone: ________________________

Who 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

Person who would be contacted if the primary caregiver is reachable

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:
   (Fill all that apply)
   Bus  Car  Taxi  Train  Walk

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

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.

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

H. DOMESTIC FACILITIES

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:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Form 1: Paediatric Patient Registration
Page 3 of 3

4947076782
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.**
FORM 2: PAEDIATRIC BASELINE CLINICAL EXAMINATION

A. CURRENT/PREVIOUS ARV MEDICATION

1. Is the patient on any antiretroviral therapy at present or have ARVs been taken in the past? (If Yes, refer to nodal site)
   - Yes  
   - No

   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? (If Yes, refer to Specialist Site)
   - Yes
   - No

   1a. If so, how many times:

   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? (If Yes, refer to Dietician - Section K)
   - Yes
   - No

   Medication  | Current Use  | Comments
   ------------|--------------|---------
   Cotrimoxazole (Bactrim)  | Yes  | Unknown
   Fluconazole (Diflucan)    |       | Multi Vitamins
   Traditional Medicine      | Yes  | Unknown
   Nutritional Supplements:  | MVTs | Yes  | Unknown
   Other                     | Yes  | Unknown
   Other 1 (specify):        | Yes  | Unknown
   Other 2 (specify):        | Yes  | Unknown

   State the name of the Medication

2. Has the patient been Dewormed? (If Yes, date of last dose)
   - Yes
   - No

3. Has the patient had Vitamin A dose? (If Yes, date of last dose)
   - Yes
   - No

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

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Form 2: Paediatric Baseline Clinical Examination
Page 1 of 4
D. TUBERCULOSIS

1. Is the patient currently being treated for Tuberculosis?
   - No (Specify)
   - Yes (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?
   - Yes
   - No

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

   1c. Date Treatment was last taken:

   When was TB Treatment started:

   E. PHYSICAL EXAMINATION

   Weight:  kgs
   Temperature: °C
   Head Circumference:  cm
   BSA:  m²

   BSA calculation: \( \text{BSA} = \frac{\text{Weight} \times \text{Height}}{3600} \)

<table>
<thead>
<tr>
<th>Examinations</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments/Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>JACCO</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Oral (teeth, mouth)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Parotids</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Hepatosplenomegaly (Abdomen)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Other (Specify):</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

______________________________

______________________________

______________________________

______________________________

______________________________
### F. DEVELOPMENTAL MILESTONES

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

<table>
<thead>
<tr>
<th>Examinations</th>
<th>Age</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Motor</td>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Scholastic</td>
<td></td>
<td>○</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

### G. PUBERTAL DEVELOPMENT

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

<table>
<thead>
<tr>
<th>Examinations</th>
<th>Tanner Stage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
</tr>
<tr>
<td>Pubic Hair</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
</tr>
<tr>
<td>Penis/Scrotum</td>
<td>○ ○ ○ ○ ○</td>
<td></td>
</tr>
</tbody>
</table>

Comments:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

### H. STAGING

1. What is the patient’s WHO Stage:

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

Comments:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

WHO = World Health Organisation
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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Recommendation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cotrimoxazole (Bactrim)</td>
<td>☐ Start ☐ Stop ☐ Continue</td>
<td>☐ Traditional Medicine MUST be discontinued</td>
</tr>
<tr>
<td>Fluconozole (Diflucan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Supplements:</td>
<td>MVTs ☐ Other ☐</td>
<td></td>
</tr>
<tr>
<td>Vitamin A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthelminthic (Deworm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 1 (specify):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 2 (specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

Reason for Referral:

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  y  y  y  y  y  y

Time:  
   h  h  m  m  (24 hrs - eg. 13:30)
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.
FORM 3: PAEDIATRIC PATIENT COUNSELLING FORM

(Form filled in by Counsellor)

A. GROUP COUNSELLING SESSIONS

- Positive Living
  - Due Date: __/__/____
  - Attend: __ Yes __ No
  - Date Attended: __/__/____

- Drug Adherence
  - Due Date: __/__/____
  - Attend: __ Yes __ No
  - Date Attended: __/__/____

- Nutritional Assessment
  - Due Date: __/__/____
  - Attend: __ Yes __ No
  - Date Attended: __/__/____

- Other Patient Training
  - Due Date: __/__/____
  - Attend: __ Yes __ No
  - Date Attended: __/__/____

B. DISCLOSURE

1. To whom has the patient’s HIV status been disclosed? (Fill all that apply)
   - Parent(s)
   - Household Member
   - Family Member
   - Health Care Worker
   - Other (1) (Specify)
   - 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?
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.
### FORM 4: PAEDIATRIC BASELINE LABORATORY RESULTS

#### A. HIV TEST
- **Type of Test:**
  - Elisa
  - PCR
- **Date Tested:**
  - d / m / y

#### B. CD4 RESULT
- **CD4%:**
- **Date Tested:**
  - d / m / y

#### C. HAEMATOLOGY
- **Lymphocyte:**
  - \( \times 10^9 \) /L

#### D. CHEMICAL PATHOLOGY
- **Amylase:**
  - IU/L
- **Cholesterol:**
  - mmol/L
- **Glucose:**
  - mmol/L
- **Triglycerides:**
  - mmol/L

#### E. LIVER FUNCTION TESTS
- **ALT:**
  - IU/L

#### F. TUBERCULOSIS
- **TB Skin Test:**
  - Positive
  - Negative
- **AFB:**
  - Positive
  - Negative
- **Chest X-Ray:**
  - Normal
  - Abnormal

#### G. VIROLOGY
- **Viral Load:**
  - copies/ml
- **Viral Load Log:**
  - d / m / y

#### H. OTHER TESTS
- **Other Tests:**
- **Date Tested:**
- **Result:**
  - Positive
  - Negative

---

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.

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.

Specify any other test ordered for the patient.
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.
**FORM 5: PAEDIATRIC PRESCRIPTION FORM**

(Form filled in by Doctor)

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

### 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:

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reg 1 (&lt;3yrs)</td>
<td>Lamivudine (3TC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stavudine (D4T)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kaletra</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reg 1 (&gt;3yrs)</td>
<td>Lamivudine (3TC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stavudine (D4T)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Efavirenz (EFV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reg 2 (&lt;3yrs)</td>
<td>Didanosine (ddI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zidovudine (AZT)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Efavirenz (EFV)/Nevirapine (NVP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reg 2 (&gt;3yrs)</td>
<td>Didanosine (ddI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zidovudine (AZT)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kaletra</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### B. NON-ARV MEDICATION

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cotrimoxazole (Bactrim)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluconazole (Diflucan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MVTs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthelminthic (Deworm)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 1 (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 2 (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C. DRUG SUBSTITUTION

(Determined by nodal site)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
</table>

List all the drugs that make up the modified regimen.

Full Name of Prescriber: 
Qualification: 
Prescription Date: 
Signature: 

---

This is the PRESCRIPTION FORM the Clinician uses to ORDER the medication.
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.
FORM 6: PAEDIATRIC PATIENT FOLLOW-UP

(A form filled in by Doctor/Clinician)

Birth Registration/SA ID Number: ____________________________
Clinician: ____________________________
Date of Visit: ____________________________

A. PRESENTING COMPLAINTS  (Information gathered through indirect questioning)

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

<table>
<thead>
<tr>
<th>Complaint/Symptom</th>
<th>Yes</th>
<th>Complaint/Symptom</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Sores</td>
<td>☐</td>
<td>Abdominal Pains</td>
<td>☐</td>
</tr>
<tr>
<td>Rash</td>
<td>☐</td>
<td>Nausea/Vomiting</td>
<td>☐</td>
</tr>
<tr>
<td>Cough</td>
<td>☐</td>
<td>Dizziness</td>
<td>☐</td>
</tr>
<tr>
<td>Fever</td>
<td>☐</td>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>☐</td>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td>☐</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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 last visit?  ☐ Yes  ☐ No
   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  ☐ ARV Site ran out of medicine
   ☐ Caregiver Forgot  ☐ Caregiver Status Change
   ☐ Felt too ill  ☐ Other  ☐ 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:
       ____________________________________________

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)

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

See section M on page 4 of this form to indicate referral to Adherence Team.
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 kg  BSA m²

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:

BSA = Body Surface Area

BSA calculation

Form 6: Paediatric Patient Follow-up
Page 2 of 4

9300395605
F. TOXICITY MONITORING/ADVERSE EVENTS

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

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>YES</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>COMMENTS/SPECIFY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous Systems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LAB TEST  YES  1  2  3  4

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not on Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphocyte</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify other here)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify other here)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Examinations</th>
<th>Age</th>
<th>Normal</th>
<th>Static</th>
<th>Regressing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Motor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scholastic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Recommendation</th>
<th>Start</th>
<th>Stop</th>
<th>Continue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cotrimoxazole (Bactrim)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluconazole (Diflucan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Supplements:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MVTs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthelmintic (Deworm)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 1 (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 2 (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

All traditional medication to the DISCONTINUED.

Form 6: Paediatric Patient Follow-up  Page 3 of 4  0786395604
KwaZulu Natal Department of Health
Comprehensive Care Programme

K. LAB INVESTIGATIONS (To Order)
- Viral Load
- FBC
- LFTs
- TB Skin Test
- AFB
- Chest X-Ray
- Lipids
- Glucose
- Hepatitis B (if >8yrs)
- Other (Specify):

L. REFERRALS
- Social Work
- Counselling
- Other (Specify name and reason)
- Reason for Referral

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

M. ARV TREATMENT SUMMARY/ACTION
1. Summary of the patient's health:
   - Stable
   - Improvement
   - Deterioration
2a. 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)
   - Change Whole Regimen (Refer to nodal site)
   - Treatment Interrupted
   - Resume Treatment
   - Terminate Treatment
   - Name of Specialist Consulted:
   - Old Drug:
   - New Drug:
   - New Regimen:

Specify the name of the Specialist Consulted who authorised the drug substitution
Indicate if this is a change to the whole Regimen.
Specify the name of the Specialist Consulted to authorise the whole regimen change
If treatment is terminated then an EXIT form (Form 8) MUST be completed

Has the patient's health remained the same, improved or deteriorated since the last examination

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

Next Appointment Date: [dd] / [mm] / [yyyy]
Time: [hh]:[mm] (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.
Form 7: Paediatric Inter-Hospital Transfer Form

**A. PATIENT DETAILS**

<table>
<thead>
<tr>
<th>Birth Registration/SA IDNumber</th>
<th>Patient Firstname</th>
<th>Patient Surname</th>
<th>Telephone/Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B. PRIMARY CAREGIVER INFORMATION**

<table>
<thead>
<tr>
<th>Firstname</th>
<th>Surname</th>
<th>Tel (home)</th>
<th>Tel (work)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**C. REASON FOR TRANSFER**

1. Please specify the reason for the transfer:  
   - Closer Site  
   - Change in Residential Address  
   - Other  
   (If Other, Specify Reason)

Has the first appointment been made:  
- Yes  
- No  
If Yes, when  
Date of receipt of Transfer Form:  
- Yes  
- No  
(Only enter numbers - No brackets or dashes)

Has the first appointment been made:  
- Yes  
- No  
If Yes, when  
Date of receipt of Transfer Form:  
- Yes  
- No  
(Only enter numbers - No brackets or dashes)

Has the first appointment been made:  
- Yes  
- No  
If Yes, when  
Date of receipt of Transfer Form:  
- Yes  
- No  
(Only enter numbers - No brackets or dashes)
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.
**FORM 8: PAEDIATRIC PATIENT EXIT FORM**

(Form filled in by Counsellor)

<table>
<thead>
<tr>
<th>Birth Registration/SA ID Number:</th>
<th>Capturer:</th>
<th>Exit Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>d / m / y</td>
</tr>
</tbody>
</table>

**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)*

**1. Request to discontinue with the programme**

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

1b. What were the reasons:

**2. Patient known/reported to be deceased**

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

3b. Please specify the contributory factors for Defaulting:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Not coping</th>
<th>Disinterested</th>
<th>Deceased</th>
<th>Too sick</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Caretaker</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

3c. Source of Information:
- Patient
- Caregiver
- Friend/Relative
- Other *(Specify):__________________________*

---

Form 8: Paediatric Patient Exit Form

Page 1 of 1

3476423368
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.
## Form 9: Paediatric Checklist

**Clinician:**

**Checklist Date:**

**Birth Registration/SA ID Number:**

**Drug Ready**

**ARV Start Date**

<table>
<thead>
<tr>
<th>ACTION</th>
<th>DONE</th>
<th>DATE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Registered</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>CD4% Taken</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>WHO Staging</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Non-ARV Medicine Prescribed</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>HIV Status Disclosed</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>- To Family</td>
<td>(Family must be Yes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- To Child</td>
<td>(If child is &gt;12yrs then Yes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Caregiver</td>
<td>O Yes</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Positive Living</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Drug Readiness</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Drug Adherence</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Baseline Blood</td>
<td>O Yes</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Nutritional Assessment</td>
<td>O Yes</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Caregiver Knowledge</td>
<td>1. Drug Names: O Yes O No</td>
<td>2. Drug Doses: O Yes O No</td>
<td></td>
</tr>
<tr>
<td>TB Excluded</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>If No, TB treated for more than 2 months:</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>Drug Ready</td>
<td>O Yes O No</td>
<td>d d / m m / y y y y</td>
<td></td>
</tr>
<tr>
<td>ARV Start Date</td>
<td>d d / m m</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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

The Clinician has ascertained that the patient does not have TB.

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

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

Supplements: O Yes O No

If the patient is ready to begin treatment?

---

(Form filled in by Clerk/Data Capturer and Clinician)
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.
## PAEDIATRIC VISIT SUMMARY FORM

<table>
<thead>
<tr>
<th>Birth Registration/SAID Number</th>
<th>PAEDIATRIC VISIT SUMMARY FORM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital File Number</td>
<td>KwaZulu Natal Department of Health Comprehensive Care Programme</td>
</tr>
<tr>
<td>Treatment Start Date</td>
<td></td>
</tr>
</tbody>
</table>

### Date of Visit

| / | / | / | / | / | / | / | / |

### Age

### WHO Staging

### Height (cm)

### % Expected Height

### Weight (kg)

### % Expected Weight

### Head Circumference (cm)

### BSA

### Development (Normal/Slow/Progressive)

### TB Symptoms (Tick=Yes)

### Months on TB Treatment

### Problems during last visit

| 1 |
| 2 |
| 3 |
| 4 |

### Bloods Taken (Tick=Yes)

<table>
<thead>
<tr>
<th>Blood Result</th>
<th>CD4%</th>
<th>Viral Load</th>
<th>Hb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Tests

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Treatment Regimen

### Months on Regimen

### Change in Treatment Regimen

### No. of Missed Doses

### Adverse Events/ Side Effects

<table>
<thead>
<tr>
<th>Event / Grade</th>
<th>Event / Grade</th>
<th>Event / Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Non-Antituberculosis Medication

<table>
<thead>
<tr>
<th>M/VTs / Vit A / Worm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bactrim</td>
</tr>
<tr>
<td>Fluconazole</td>
</tr>
</tbody>
</table>

### Referrals (Tick=Yes)

<table>
<thead>
<tr>
<th>Social Work</th>
<th>Counselling</th>
<th>Other / Special</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social

<table>
<thead>
<tr>
<th>Change in Address</th>
<th>Change in Caregiver</th>
<th>Grants</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

### Action

### Comments

### Captured By

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English Version 1.0