



Medication Adherence Assessment

Administer at each follow up visit if patient on ARV, TB or OI medications.

Facility Name: _____ Visit Date (dd/mm/yyyy) _____ / _____ /20

Name _____

 Surname Other Names

ID _____ - _____ - _____ Hospital No. _____
 State Facility No. Serial Enrollment No.

Sex F M DOB (dd/mm/yyyy) _____ / _____ / _____ Age _____ years If < 5 years _____ months

I have questions about the medications you (or your child) took over the last three days. Most people have to take many pills everyday for their diseases. We are trying to understand your medication adherence habits, so please share with us your routine in taking your meds.

1. List all current ARV medications and doses missed.

ARV Med Name, Dosage, Frequency	No. of Doses Missed		
	Yesterday	During the past week	During the past month

2. How often do you feel that you have difficulty taking your HIV medications on time? By "on time," we mean no more than 2 hours before or 2 hours after the time you agreed to take it.

All of the time Rarely
 Most of the time Never

3. On average, how many days PER WEEK would you say that you missed at least one dose of your HIV medications?

Every day Once a week
 4-6 days per week Less than once a week
 2-3 days per week Never

4. When was the last time you missed at least one dose of your HIV medications?

Within the past week Between 1 and 3 months ago
 1-2 weeks ago More than 3 months ago
 3-4 weeks ago Never

5. Taking medications everyday can be difficult. What were the most common reason(s) for not taking or missing your medications during the last visit?
 Not applicable / did not miss taking any of my medications.

Possible Reasons for Missed or Delayed Medications

A.

- Forgot
- Fell asleep / slept through dose
- Change in routing / away from home
- Busy / working / at school
- Got pregnant
- Patient moved
- Lost medication / Ran out of medications / Pharmacy or dispensary did not have any medications
- Not able to pay
- Felt better
- Felt sick / bad (for example, nausea or vomiting)
- Toxicities / drug side effects
- Felt overwhelmed / depressed
- Did not understand how to take medications
- Did not want to take medications
- Stigma / discrimination / privacy issues
- Too many pills
- Other (specify): _____
- Other (specify): _____
- Other (specify): _____

B. Child Specific:

- Refuses to take medications
- Spits medications out
- Vomits medications
- Did not understand how to give medications
- Caregiver did not want to give medications
- Caregiver moved
- Change in caregiver

6. Patient has disclosed status to: No one Family member Spiritual leader Friend Spouse Other

7. Next steps to improve patients adherence: None needed

Use pillbox Use Treatment Partner (an HIV+ peer, friend or family member). Who: _____

Time pill taking with daily routine (i.e. prayers, eating, radio program)

Use patient educational modules (specify) Use WOT (Weekly Observed Therapy) with pillbox. Specify visit day: _____

Attend support group meeting. When: _____
 Where: _____

Talk to a TSS (Treatment Support Specialist). Name: _____

Make medications more palatable (add flavor to medications)

Other _____

Other _____

Adherence Counselor Name _____ Adherence Counselor Signature _____ Date (dd/mm/yyyy) _____