Adherence Strategy Workplan

Visit Date / /

Administer if Patient (1) starting ARV therapy, or (2) on a follow-up visit and NOT on ARV therapy.
(Otherwise, use *Medication Adherence Assessment* form).

Patient Name _____ _____
Surname Other Names

Patient ID ___ ___ ___ - ___ ___ ___ - _____

Hospital ID _____

Sex ◯ **F** ◯ **M** **Age** ___ years If < 5 years ___ months

I. Physician Recommended the Patient to Talk to an Adherence Team Member ◯ Yes ◯ No

(List name) _____

II. Patient's Adherence Strategy Workplan: (specific order listed not required)

1. Recommend attendance at a "HIV Basics" seminar ◯ Yes ◯ No

2. Recommend attendance at an "Adherence Basics" seminar ◯ Yes ◯ No

3. Discuss patient's preferred adherence strategy (select one)

* DOT Directly Observed Therapy ◯
* WOT Weekly Observed Therapy ◯
* TP Treatment Partner ◯
* SMA Self-Managed Adherence ◯

4. Conduct a 1-week practice trial to simulate the commitment and attention necessary for BID dosing to ARV medications

Prescribe:

* 1 MVI QD ◯ Yes ◯ No
* 1 Co-trimoxazole (Septrin) QD ◯ Yes ◯ No
* Other med / frequency _____
* Other med / frequency _____

5. Patient ready to sign ARV Adherence Commitment Form ◯ Yes ◯ No

List adherence strategy selected: _____

6. Attend a support group meeting ◯ Yes ◯ No

* Next one on: _____ At _____ AM / PM
* Where: _____

7. Other: _____

III. Patient is ready to start ARV meds. (If YES, go to Pharmacy Order Form.) ◯ Yes ◯ No

IV. Patient is not ready to start ARV meds. (Re-assess patient's ARV treatment readiness.) ◯ Yes ◯ No

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