

This document was developed by ACTION Project and intended to help health providers (clinician, nurse, lab technician, pharmacist, adherence counselor, health administrative, etc) in completing PMM forms used in PEPFAR program.

## B. General Instruction

All forms consist of 3 general sections, i.e.: (1) Header (patient's personal information), (2) Main Body (patient's relevant health assessment data) and (3) Footer (information of when and who fills the forms)

- (1) Header and Footer sections must be filled to ensure that patient's data can be maintained and retrieved whenever it's necessary.
- (2) Main Body section should be filled with the best effort so that the patient's progress can be well monitored and evaluated.
- (3) Date is always in dd/mm/yyyy format.
- (4) Enter patient's full name and hospital number on the top of every page of the forms.
- (5)
- (6)

## C. Forms Instruction

This part will explain how to fill each form number by number. There are 9 PMM forms in PEPFAR program, which are:

1. Personal History Form
2. Adult Initial Clinical Evaluation Form
3. Adult Follow-up Clinical Encounter Form
4. Paediatric Initial Clinical Evaluation Form
5. Paediatric Follow-up Clinical Encounter Form
6. Laboratory Order and Result Form
7. Pharmacy Order Form
8. Medication Adherence Assessment Form
9. Contact Tracking and Termination Form

Following is the instruction to complete each form.

### 1. Personal History Form Instruction

This form must be completed in the very beginning, to enroll the patient in PEPFAR program.

No 1 - 6 is mandatory and must be filled with the best effort and clear

- |                               |   |
|-------------------------------|---|
| <b>1. Visit Date</b>          | Enter the date of visit when the patient enrolls to the PEPFAR program; started with 2 digits of day, 2 digits of month and 4 digits of year.<br><b>Note: this is not the date when the patient first time enrolled/registered in this hospital/facility.</b> |
| <b>2. Patient Name</b>        | Enter patient's surname and other names if any.   |
| <b>3. Hospital (Unit) No.</b> | Enter patient's designated hospital number.<br><b>Note: in most case, it is patient's identifying number when s/he first time registered in this hospital/facility.</b>   |
| <b>4. ID</b>                  | <b>State:</b> Enter the state abbreviation in the state boxes.<br><b>Facility No:</b> Enter the designated facility number.<br><b>Serial Enrolment No:</b> Enter patient's number when s/he was first   |

time enrolled into PEPFAR program.

5. Sex Tick the check box for patient's gender.
6. Age Enter the patient's age. If the patient is not yet 5 year old, enter the months in the space provided.
7. Date of Birth If known, enter the patient's date of birth. Started with 2 digits of day, 2 digits of month, and 4 digits of year of birth.

No 8 - 16 are filled for ADULT and PEDIATRIC patients

8. Where does the patient live? Enter the information where the patient resides.
9. Contact Person / Next of Kin Enter the contact person's name and address of the patient.  
**Note: preferably a person who can make decision for patient.**
10. Marital Status Tick the patient's marital status. Tick **N/A** for paediatric patient.  
**Widowed:** the husband/wife has deceased.  
**Divorced:** legally separated.  
**Married:** legally married.  
**Separated:** does not live together as husband and wife but not legally divorce.
11. Educational Level Tick patient's educational level. If **Other** is ticked, specify it in the provided space. Tick **N/A** for paediatric patient.
12. Preferred Language Indicate patient's preferred language in communication.
13. Patient's Job Status Enter patient's job status. If **Other** is ticked, specify it in the provided space. Tick **N/A** for paediatric patient.
14. How long would it take you to arrive at the hospital? Indicate the hour and minute (approximately) since patient left the house until s/he arrived at the hospital.
- 15 a. How many dependents are at home? Enter the number of people that are still financially depending in the household; include extended family, such as sister, nephew, grandmother, etc., if they are financially depending.
- 15 b. How many of them are under 18 years old? Enter the number of under 18 years old of the number that patient provides in 15 a.
16. Service entry into program: Tick from which service entry the patient enters PEPFAR program.

No. 17 - 22 are filled for PAEDIATRIC patient only.

17. With whom does child live? Enter the name and the relationship of the person whom the child lives with.
- 18 a. Is the mother of child live? Indicate if the mother of the child is still alive. If the mother is alive, enter her name in the space provided. If the mother does not live

with the child, then provide the mother's address.

- 18 a. Is the father of child live? Indicate if the father of the child is still alive. If the father is alive, enter his name in the space provided. If the father does not live with the child, then provide the father's address.
19. Child's parents/caregivers are: Indicate whether the child's parents/caregivers are married and living together.
20. Job/occupation status of child's parents/caregivers: Indicate child's mother/father/caregiver's occupation based on the Job Codes provided. If code 1 is chosen, specify the type of employment in the space provided.
21. Educational level of child's parents/caregiver: Indicate child's mother/father/caregiver's educational level based on the Educational Codes provided. If code 7 is chosen, specify the type of education in the space provided.
22. How many siblings does the child have? Indicate the number of siblings of the child, not necessarily live in the same house.

## 2. Adult Initial Clinical Evaluation Form Instruction

No 1 - 6 is mandatory and must be filled with the best effort and clear

1. Visit Date Enter the date of visit when the patient is evaluated for the first time by clinician in PEPFAR program; started with 2 digits of day, 2 digits of month and 4 digits of year.  
**Note: this is not the date when the patient first time enrolled/registered in this hospital/facility.**
2. ID  
**State:** Enter the state abbreviation in the state boxes.  
**Facility No:** Enter the designated facility number.  
**Serial Enrolment No:** Enter patient's number when s/he was first time enrolled into PEPFAR program.
3. Hospital (Unit) No. Enter patient's designated hospital number.  
**Note: in most case, it's patient's identifying number when s/he first time registered in this hospital/facility.**
4. Patient Name Enter patient's surname and other names if any.
5. Sex Tick the check box for patient's gender.
6. Date of Birth If known, enter the patient's date of birth. Started with 2 digits of day, 2 digits of month, and 4 digits of year of birth.
7. Age Enter the patient's age. If the patient is not yet 5 year old, enter the months in the space provided.
8. Presenting complaint Enter patient's reason for this visit.
9. Symptom review Tick Y if the symptom(s) occur and tick N if not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.

10. **Additional comments**                      Indicate any additional comments on the patient's symptom review.
11. **Past medical problems**                      Indicate patient's past medical problems if any.
12. **Family history**                                  Indicate patient's family medical history.
13. **Hospitalization**                                  Indicate if patient has ever been hospitalized, for what reason and for how long.
14. **Drug allergies**                                  Enter patient's drug allergies if any.
15. **Have you ever received treatment for an illness by a native doctor/traditional healer?**                      Tick Y if patient has received treatment, tick N if has never.
- 16 a. **Last menstrual period**                      Enter the first day of the last normal menstrual period. Skip to no. 17 if the patient is male.
- 16 b. **Currently pregnant**                              Tick Y if the patient is pregnant, N if not, Uncertain if the patient is not sure. Skip to no. 17 if N or Uncertain is ticked.
- 16 c. **Gestational age**                                  Enter the gestational age (age of pregnancy) to the last completed weeks.
- 16 d. **Expected date of delivery**                      Enter the expected date of delivery, if known.
17. **Latest CD4**    Enter the latest CD4, if available. Enter the date of the latest CD4 count. Tick which method was used for the last CD4 count.  
**Note:**  
- GON patients more likely to have CD4 count available.  
- Skip to no. 20 for naive patient.
18. **Lowest CD4**    Enter patient's lowest CD4 result if available along with the date of the test result. Tick **lab records seen** if the clinician sees the lab result.
19. **Latest VL**    Enter the latest VL, if available. Enter the date of the latest VL. Tick **lab records seen** if the clinician sees the lab result.
20. **Previous ARV exposure (probe)**                      Indicate what type of ARV exposure that patient ever had in the past and specify it in the space provided. Tick **None** if patient has never had one.
21. **Current medications (probe and specify)**                      Tick patient's current medications and specify the medications in the space provided. If patient is not under any medication, tick **None**.
22. **Adherence**  
a. **Participating in an adherence program**                      Tick Y if patient is participating in an adherence program; N if not. If the patient ever missed ARV in the last 3 days or during last week, tick Y, otherwise tick N. If there is missed medication, enter code number from **Reason Codes** for why patient mostly missed the

	medications.
b. Treatment was interrupted (unintentional)	If treatment for patient is interrupted unintentionally, tick <b>Y</b> ; tick <b>N</b> if not. Enter the date of the first day the treatment is interrupted. Indicate the reason of interruption based on the <b>Reason Codes</b> .
c. Treatment was stopped (intentional)	If treatment is stopped intentionally, tick <b>Y</b> ; tick <b>N</b> if not. Enter the date of the first day the treatment is stopped, and enter number of the days treatment has been stopped. Indicate the reason of stopping medications.
23. Past or current ARV side effects	Tick any side effects that occur. If no side effect occurs, tick <b>None</b> . If side effect is not listed here, tick <b>Other</b> and specify it in the space provided.
24. Physical exam	<b>Temp:</b> Indicate patient's body temperature in Celsius. <b>BP:</b> Indicate patient's BP. <b>Pulse:</b> Indicate patient's pulse. <b>Weight:</b> Enter patient's weight in kilogram. <b>Height:</b> Enter patient's height in meter. If any, indicate significant findings on physical exam. If none found, tick <b>NSF</b> . If the finding is not listed, indicate it in the space provided.
25. Assessment	Indicate clinician's assessment
26. WHO staging criteria	Tick any of the symptoms/illnesses listed if ever occurred to patient.
27. WHO stage	Indicate WHO stage based on WHO staging criteria ticked.
28 a. Plan	Clinician indicates the treatment plan until patient's next visit.
28 b. Plan (specify orders on requisition)	Tick the chosen plan and specify it in the space provided.
29. Enroll in	Indicate where the patient currently enrolled in.
30. ARV therapy plan	Indicate the ARV therapy plan. If the <b>Change Treatment</b> or <b>Stop ARV Therapy</b> is ticked, enter the code number from <b>Reason Codes</b> for why the option is chosen.
31 a. Regimen	Tick the regimen that the patient is currently in.
31 b. Drugs in regimen	Indicate the specific drugs in regimen. <b>WHAT'S THE DIFFERENCE BETWEEN NO 31 A. AND 31 B?</b>
32. Patient has disclosed status to	Indicate to whom patient has disclosed his/her HIV/AIDS status. If the patient has not disclosed it to anybody, tick <b>No One</b> option. If other is chosen, specify the person.
33. HIV status can be discussed with	Indicate to whom HIV status of patient can be discussed with (preferably a person who can make decision for the patient in case of emergency).
34 a. Patient has received	If patient has ever received care for HIV/AIDS, choose from the

care for HIV/AIDS from	options listed.
34 b. Specify facility name	Enter the facility name where the patient has received treatment mentioned in no. 34 a.
35. Is the patient a member of a support group	Tick Y if patient is a member of a support group, otherwise tick N.
36. Additional notes	Enter any important additional notes related with patient's evaluation.
37. When is patient's next appointment?	Tick patient's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician signature	Clinician who provides initial evaluation signs in the space provided.
Print name	Enter the full name of the clinician.

### 3. Follow-up Clinical Encounter Form Instruction

No. 1 - 6 is mandatory and must be filled with the best effort and clear.

1. Visit Date	Enter the date of the follow-up visit; started with 2 digits of day, 2 digits of month and 4 digits of year. <b>Note: this is not the date when the patient first time enrolled/registered in this hospital/facility.</b>
2. ID	<b>State:</b> Enter the state abbreviation in the state boxes. <b>Facility No:</b> Enter the designated facility number. <b>Serial Enrolment No:</b> Enter patient's number when s/he was first time enrolled into PEPFAR program.
3. Hospital (Unit) No.	Enter patient's designated hospital number. <b>Note: in most case, it is patient's identifying number when s/he first time registered in this hospital/facility.</b>
4. Patient Name	Enter patient's surname and other names if any.
5. Last CD4 count	Enter patient's last CD4 count, if known.
6. Last VL	Enter patient's last Viral Load, if known.
7 a. Current ART regimen	Enter the date of patient started using current ART regimen.
7 b. Regimen	Enter drugs in regimen patient is currently using.
7 c. Regimen is	Tick whether patient regimen is in <b>1st line</b> , <b>2nd line</b> or <b>Salvage</b> .

#### Medical History

8. Symptom review	Tick Y if the symptom(s) occur and tick N if not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.
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9. Illnesses since last visit      Indicate any illnesses since patient's last visit. If none, skip to **no 10**.
10. Hospitalization since last visit      Indicate if patient has been hospitalized since last visit, for what reason and for how long. If none, skip to **no. 11**.
11. Since your last visit, have you received treatment for an illness by a native doctor or traditional healer?      Tick Y for yes, N for no.
- 12 a. Last menstrual period      Enter the first day of the last normal menstrual period.  
**Note: Skip to no. 13 if patient is Male.**
- 12 b. Currently pregnant      Tick the correct option. If **N** or **Uncertain** is ticked, continue to **no. 13**.
- 12 c. Gestational age      Enter the gestational age (age of pregnancy) to the last completed weeks.
- 12 d. Expected date of delivery      Indicate expected date of delivery if known.
13. Current medication      Tick patient's current medications and specify them. If there is no current medication tick **None**.
14. Past or current ARV side effects      Tick any ARV side effects that have occurred since last visit, or are occurring now. If no side effect, tick **None**. If the side-effects occurred are not listed, tick **Other** and specify the side effect.
- 15 a. Participating in an adherence program:      Tick Y or N to indicate whether patient is participating in an adherence program.  
Indicate whether patient ever missed medication in the last 3 days or during last week.  
If patient ever missed medications, enter code from **Reason Codes** for why patient missed medications.
- 15 b. Treatment was interrupted (unintentional)      Indicate whether treatment was interrupted unintentionally.  
Enter the date of the first day the treatment was interrupted.  
In the box provided, enter how many days treatment was interrupted.  
Enter code from **Reason Codes** for why treatment was interrupted.
- 15 c. Treatment was stopped (intentionally)      Indicate whether the treatment was interrupted intentionally.  
Enter the date of the first day the treatment was interrupted intentionally.  
In the box provided, enter how many days the treatment stopped.  
Enter code from **Reason Code** for why treatment was interrupted intentionally.
16. Physical exam      **Temp:** Indicate patient's body temperature in Celsius.  
**BP:** Indicate patient's BP.  
**Pulse:** Indicate patient's pulse.  
**Weight:** Enter patient's weight in kilogram.  
**Height:** Enter patient's height in meter.

If any, indicate significant findings on physical exam. If none found, tick **NSF**. If the finding is not listed, indicate it in the space provided.

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|--|--|
| 17. Assessment                             | Indicate clinician's assessment  |
| 18. WHO staging criteria                   | Tick any of the symptoms/illnesses listed if ever occurred to patient.   |
| 19. WHO stage                              | Indicate WHO stage based on WHO staging criteria ticked.   |
| 20 a. Plan                                 | Clinician indicates the treatment plan until patient's next visit.   |
| 20 b. Plan (specify orders on requisition) | Tick the chosen plan and specify it in the space provided.   |
| 21. ARV therapy plan                       | Indicate the ARV therapy plan. If the <b>Change Treatment</b> or <b>Stop ARV Therapy</b> is ticked, enter the code number from <b>Reason Codes</b> for why the option is chosen. |
| 22. Regimen                                | Tick the regimen that the patient is currently in.   |
| 23. Additional notes                       | Enter any important additional notes related with patient's evaluation.  |
| 24. When is patient's next appointment?    | Tick patient's next appointment for follow-up evaluation. Specify the date in the space provided.  |
| Clinician signature                        | Clinician who provides initial evaluation signs in the space provided.   |
| Print name                                 | Enter the full name of the clinician.  |

#### 4. Paediatric Initial Clinical Evaluation Form

No 1 - 6 is mandatory and must be filled with the best effort and clear

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|------------------------|--|
| 1. Visit Date          | Enter the date of visit when the patient is evaluated for the first time by clinician in PEPFAR program; started with 2 digits of day, 2 digits of month and 4 digits of year.<br><b>Note: this is not the date when the patient first time enrolled/registered in this hospital/facility.</b> |
| 2. ID                  | <b>State:</b> Enter the state abbreviation in the state boxes.<br><b>Facility No:</b> Enter the designated facility number.<br><b>Serial Enrolment No:</b> Enter patient's number when s/he was first time enrolled into PEPFAR program.   |
| 3. Hospital (Unit) No. | Enter patient's designated hospital number.<br><b>Note: in most case, it is patient's identifying number when s/he first time registered in this hospital/facility.</b>  |
| 4. Patient Name        | Enter patient's surname and other names if any.  |
| 5. Sex                 | Tick the check box for patient's gender.   |

6. **Date of Birth** If known, enter the patient's date of birth. Started with 2 digits of day, 2 digits of month, and 4 digits of year of birth.
7. **Age** Enter the patient's age. If the patient is not yet 5 year old, enter the months in the space provided.
8. **Presenting complaint** Enter patient's reason for this visit.
9. **Symptom review** Tick Y if the symptom(s) occur and tick N if not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.
10. **Additional comments** Indicate any additional comments on the patient's symptom review.
- 11 a. **Developmental Assessment: please check the most advanced milestone** Clinician ticks child's most advanced milestone.
- 11 b. **Has the patient lost developmental milestones?** Indicate whether child has lost any developmental milestones.
- 11 c. **Is the child in school?** Indicate whether child is in school. If yes, provide the name of the school. If not, skip to no. 12.
- 11 d. **School performance** (1) Indicate in which class/grade the child is in.  
(2) Indicate whether child's performance in class is satisfactory.
- 12 a. **Past medical history** Enter child's past medical history, including any hospitalization and surgery. Indicate the reason and the period of time of hospitalization and surgery.
- 12 b. **Past drug history/allergies** Indicate child's past drug history and allergies.
- 12 c. **Immunisation** Tick immunizations from the list that have been given to the child.
13. **Family history** Indicate child's family medical history.
- 14 a. **Patient has received previous care for HIV/AIDS from** If child has ever received previous care for HIV/AIDS, indicate where the care has been received from. If none received, tick **None** and skip to no. 15.
- 14 b. **Specify facility name** Specify the facility name where the child has received previous care for HIV/AIDS from.
15. **Has the child ever received treatment for an illness by a native doctor/traditional healer/alternative health provider?** Indicate yes or no.
- 16 a. **Mode of transmission** Indicate mode of transmission to the child. If other is ticked, specify

it in the space provided.

**16 b. Booked for ANC**

**INSTRUCTION PLEASE**

16 c. Gestational age at birth Indicate mother's age of pregnancy when the child was born.

**16 d. Duration of membrane rupture**

**INSTRUCTION PLEASE**

16 e. Mode of delivery Indicate whether mode of delivery was **vaginal**, **elective Cesarean** or **non-elective Cesarean**.

16 f. Birthweight Indicate child's birthweight.

16 g. Duration of breast feeding If child was breast fed, indicate the duration of breast feeding. Tick **None** if child was not breast fed.

**16 h. Was any mixed feeding done?**

Indicate whether there was any mixed feeding done for the child. **CAN ANYBODY EXPLAIN A LITTLE BIT ABOUT MIXED FEEDING HERE?**

17. Latest CD4 Enter the latest CD4, if available. Enter the date of the latest CD4 count. Tick which method was used for the last CD4 count. **Note: GON patients more likely to have CD4 count available.**

18 a. Latest VL Enter the latest VL, if available. Enter the date of the latest VL. Tick **lab records seen** if the clinician sees the lab result.

18 b. Lowest CD4 Enter patient's lowest CD4 result if available along with the date of the test result. Tick **lab records seen** if the clinician sees the lab result.

19 a. Previous ARV exposure other than PMTCT If child has ARV exposure other than PMTCT, tick **Treatment**, indicate for how many months the treatment and specify ARV. Otherwise, tick **None**.

19 b. Previous ARV exposure through PMTCT Indicate child's previous ARV exposure through PMTCT, if any. Otherwise tick **None**. If **Other** is ticked, specify the drugs.

20. Current medications Indicate child's current medication and specify it in the space provided. If child is not under any medications, tick **None** and continue to **no. 21**.

**Complete no. 21 - 23 only if child has past history of ARV treatment. If none, skip to no. 24.**

21. Treatment was interrupted (by patient/caregiver) Indicate whether treatment was interrupted by patient/caregiver. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days the interruption. Enter code from **Reason Code** for why medication was interrupted.

22. Treatment was interrupted (by clinician) Indicate whether treatment was interrupted by clinician. Enter the date of the first day the treatment was interrupted. In the box provided, enter how many days the interruption. Enter code from **Reason Code** for why medication was interrupted.

23. ARV side effects Tick any side effects that occur. If no side effect occurs, tick **None**.

If side effect is not listed here, tick **Other** and specify it in the space provided.

24. **Physical exam**  
**Temp:** Indicate child's body temperature in Celsius.  
**BP:** Indicate child's BP.  
**Pulse:** Indicate child's pulse.  
**Weight:** Enter child's weight in kilogram.  
**Height:** Enter child's height in meter.  
**Head circumference:** Enter child's head circumference in cm.  
**MUAC:** Enter child's MUAC (Mid Upper Arm Circumference) in cm.  
**Weight for height:** Indicate whether child's weight for height is **normal**, **under** or **over**.  
If any, indicate significant findings on physical exam. If none found, tick **NSF**. If the finding is not listed, indicate it in the space provided.
25. **Assessment**  
Indicate clinician's assessment.
26. **WHO staging criteria**  
Tick any of the symptoms/illnesses listed if ever occurred to child.
27. **WHO stage**  
Indicate WHO stage based on WHO staging criteria ticked.
- 28 a. **Plan**  
Clinician indicates the treatment plan until child's next visit.
- 28 b. **Plan (order on specific requisition form)**  
Tick the chosen plan and specify it in the space provided.
29. **Enroll in**  
Indicate where the child is currently enrolled in.
30. **ART plan (if applicable)**  
Indicate ARV therapy plan for child. If **Change Treatment** or **Stop ART** is ticked, enter the code number from **Reason Codes** for why the option is chosen.
31. **Regimen (if applicable)**  
Tick the regimen that the patient is currently in and specify it.
- 32 a. **Child's status known to**  
Indicate the person(s) who know child's HIV/AIDS status.
- 32 b. **Is child aware of his/her diagnosis by name?**  
Indicate whether child is aware that his/her illness is HIV/AIDS. If child's development (e.g. 2 months old baby) does not allow him/her to understand, tick **N/A**. If **Y** is ticked skip to **no. 33**.
- 32 c. **Is child aware that he/she has chronic illness, but not by name?**  
If child is aware that s/he has chronic illness, but does not understand that it is HIV/AIDS, tick **Y**. Otherwise, tick **N**.
33. **HIV status can be discussed with**  
Indicate to whom HIV status of child can be discussed with (preferably a person who can make decision for the child in case of emergency).
34. **Is the patient's caregiver a member of a support group**  
Tick **Y** if patient's caregiver is a member of a support group, otherwise tick **N**
35. **Additional comments**  
Enter any important additional comments related with child's evaluation.

37. When is patient's next appointment?	Tick child's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician Name	Enter full name of clinician who provides child's initial evaluation.
Signature	Clinician who provides initial evaluation signs in the space provided.
Consultant Name	Enter the full name of the consultant clinician.

## 5. Paediatric Follow-up Clinical Encounter Form Instruction

No. 1 - 8 is mandatory and must be filled with the best effort and clear.

1. Visit Date	Enter the date of follow-up visit; started with 2 digits of day, 2 digits of month and 4 digits of year. <b>Note: this is not the date when the child first time enrolled/registered in this hospital/facility.</b>
2. Child Name	Enter child's surname and other names if any.
3. ID	<b>State:</b> Enter the state abbreviation in the state boxes. <b>Facility No:</b> Enter the designated facility number. <b>Serial Enrolment No:</b> Enter child's number when s/he was first time enrolled into PEPFAR program.
4. Hospital (Unit) No.	Enter child's designated hospital number. <b>Note: in most case, it is child's identifying number when s/he first time registered in this hospital/facility.</b>
5 a. Last CD4 count	Enter child's last CD4 count and the date of the test result, if known.
5 b. Last CD4%	Enter child's last CD4% and the date of the test result, if known.
6. Last VL	Enter child's last Viral Load and the date of the test result, if known.
7 a. Current ART regimen	Enter the date of the child started using current ART regimen.
7 b. Regimen	Enter drugs in regimen the child is currently using.
7 c. Regimen is	Tick whether child regimen is in <b>1st line</b> , <b>2nd line</b> or <b>Salvage</b> .
8. Age	Enter the child's age. If the child is not yet 5 year old, enter the months in the space provided.
9. Presenting complaint	Enter the reason for this visit.
10. Symptom review	Tick <b>Y</b> if the symptom(s) occur and tick <b>N</b> if not occur. Indicate how long symptom(s) occur in the Duration box, for example, 1/12 means 1 month or 3/52 means 3 weeks.
11 a. Developmental milestones attained since	Tick developmental milestones that child has attained since last visit.

last visit

- 11 b. Has the child lost developmental milestones since last visit? Indicate whether child has lost any developmental milestones since last visit. If yes, indicate in the space provided.
12. Illnesses since last visit Indicate any illnesses since child's last visit. If none, skip to no. 13.
13. Hospitalization since last visit (include duration, indication and treatment) Indicate if child has been hospitalized since last visit; include duration, indication and treatment.
14. Since last visit, has the child received treatment for an illness by a native doctor/traditional healer/alternative health provider? Indicate yes or no.
15. Current medications (probe and specify) Tick child's current medications and specify the medications in the space provided. If child is not under medication, tick **None**. If **Other** is ticked, specify the medications.
16. Possible ARV side effects (either presently or since last visit) Tick any side effects that have occurred since last visit or are occurring presently. If no side effect occurs, tick **None**. If side effect is not listed here, tick **Other** and specify it in the space provided.
17. Adherence since last visit Tick **N/A** if child is not participating in adherence program.
- a. Treatment was interrupted (by patient/caregiver) Indicate whether treatment was interrupted by patient/caregiver. Enter the date of the first day the treatment is interrupted. In the box provided, enter how many days the interruption. Enter code from **Reason Codes** for why medication was interrupted.
- b. Treatment was interrupted (by clinician) Indicate whether treatment was interrupted by clinician. Enter the date of the first day the treatment is interrupted. In the box provided, enter how many days the interruption. Enter code from **Reason Codes** for why medication was interrupted.
18. Physical exam **Temp**: Indicate child's body temperature in Celsius.  
**BP**: Indicate child's BP.  
**Pulse**: Indicate child's pulse.  
**Weight**: Enter child's weight in kilogram.  
**Height**: Enter child's height in meter.  
**Head circumference**: Enter child's head circumference in cm.  
**MUAC**: Enter child's MUAC (Mid Upper Arm Circumference) in cm.  
**Weight for height**: Indicate whether child's weight for height is **normal**, **under** or **over**.  
If any, indicate significant findings on physical exam. If none found, tick **NSF**. If the finding is not listed, indicate it in the space provided.
19. Assessment Indicate clinician's assessment.

20. Change in WHO stage since last visit?	Indicate whether WHO stage has changed since last visit.
21 a. WHO staging criteria	Tick any of the symptoms/illnesses listed if ever occurred to child.
21 b. WHO stage	Indicate WHO stage based on WHO staging criteria ticked.
22 a. Plan	Clinician indicates the treatment plan until child's next visit.
22 b. Plan (specify orders on requisition)	Tick the chosen plan and specify it in the space provided.
23 a. ART plan (if applicable)	Indicate ARV therapy plan for child. If <b>Change Treatment</b> or <b>Stop ART</b> is ticked, enter the code number from <b>Reason Codes</b> for why the option is chosen.
23 b. Regimen (if applicable)	Tick the regimen that the patient is currently in and specify it.
24. Additional comments	Enter any important additional comments related with child's evaluation.
25. When is patient's next appointment?	Tick child's next appointment for follow-up evaluation. Specify the date in the space provided.
Clinician Name	Enter full name of clinician who provides child's initial evaluation.
Signature	Clinician who provides initial evaluation signs in the space provided.
Consultant Name	Enter the full name of the consultant clinician.

## 6. Laboratory Order and Result Form Instruction

Collection Date	Enter the date of sample collection; started with 2 digits of day, 2 digits of month, and 4 digits of year. <b>Note: Must be filled</b>
Patient Name	Enter patient's surname and other names if any. <b>Note: Must be filled</b>
ID	<b>State:</b> Enter the state abbreviation in the state boxes. <b>Facility No:</b> Enter the designated facility number. <b>Serial Enrolment No:</b> Enter patient's number when s/he was first time enrolled into PEPFAR program. <b>Note: Must be filled</b>
Hospital (Unit) No.	Enter patient's designated hospital number. <b>Notes:</b> <ul style="list-style-type: none"> <li>- In most case, it is patient's identifying number when s/he first time registered in this hospital/facility.</li> <li>- Must be filled</li> </ul>
Facility Name	Enter facility name where the patient is currently enrolled and

treated  
**Note: Must be filled**

**Lab Registration No** Enter the lab registration no. where tests are run.  
**Note: Must be filled**

**Sex** Tick patient's gender

**Age** Enter age of the patient. For paediatric patient, if less than 5 years, enter the age in months.  
**Note: Must be filled**

Lab form consists of 4 sections, which are **Immunology/Virology, Hematology, Chemistry, and Microbiology**. Each part goes to designated lab. Each section has 2 columns, which are **Orders and Result**. The names of tests provided are listed in **Order** column. Clinician ticks the test s/he wants to order for patient. The person who runs the tests records the results of the ordered tests in the **Result** column. **Result** column has been equipped with units.

**Ordered by** Clinician who orders the tests enters his/her name and signature in the space provided.  
Enter the date of the tests ordered.  
**Note: Must be filled**

**Reported by** The person who runs the tests (can be lab technician or lab scientist) enter his/her name and signature in the space provided.  
Enter the date of the test results reported.  
**Note: Must be filled**

**Checked by** Lab scientist enters his/her name and signature in the space provided after checking the test results.  
Enter the date of the results checked.

## 7. Pharmacy Order Form Instruction

**Date** Enter the date of drug prescribed; started with 2 digits of day, 2 digits of month, and 4 digits of year.  
**Note: Must be filled**

**Patient Name** Enter patient's surname and other names if any.  
**Note: Must be filled**

**ID** **State:** Enter the state abbreviation in the state boxes.  
**Facility No:** Enter the designated facility number.  
**Serial Enrolment No:** Enter patient's number when s/he was first time enrolled into PEPFAR program.  
**Note: Must be filled**

**Facility Name** Enter facility name where the patient is currently enrolled and treated  
**Note: Must be filled**

**Hospital (Unit) No.** Enter patient's designated hospital number.  
**Notes:**

- In most case, it is patient's identifying number when s/he first time registered in this hospital/facility.
- Must be filled

Pharmacy Registration No	Enter the pharmacy registration no. where drugs are dispensed. <b>Note: Must be filled</b>
Do Not Dispense ARVs to Patient; Hold for Adherence Staff Pickup	Clinician ticks this if the drugs will be picked up by adherence staff.
Medication provided by	Clinician ticks whether the drugs are provided by GON, PEPFAR or other program. If <b>Other</b> is ticked, enter the name of the program that provides the drugs.

The main body of this form consists of 2 sections, which are **ARV Medication** and **OI Prophylaxis**. Each section has 7 columns, i.e. **Medications, Strength, Actual Dose, Frequency, Quantity Prescribed, and Quantity Dispensed**. Following are the instructions how to fill each column for both sections.

Name of Medications	The names of medications in <b>ARV Medications</b> are already listed. However, in <b>OI Prophylaxis</b> , for <b>Other TB Meds</b> and <b>Other</b> option, clinician needs to enter the name of the medications s/he wants to prescribe in the space provided.
Strength	Tick the strength of the selected medication. Mg/ml strength is used only for paediatric patients. <b>Note: Pay careful attention to Didanosine strength; 250 mg and 400 mg options can be used if the medication prescribed is Videx EC.</b>
Actual Dose	Enter the actual dose in the space provided. This is used only for paediatric patients.
Frequency	This column is used to determine the frequency of taking medications per day. Clinician ticks the selected frequency. The notes beside the frequency (i.e. <i>&lt;60 kg or if on rifampicin</i> ) should be taken into consideration when selecting frequency for patient.
Duration	Indicate how many days/weeks/months the prescription will be filled for.
Quantity Prescribed	Clinician enters the quantity of each medication prescribed.
Quantity Dispensed	Pharmacist enters the quantity of each medication dispensed.
Ordered by	Clinician enters his/her name and signature in the space provided. Enter the date of prescription is issued. <b>Note: Must be filled</b>
Counseled by	Adherence Counselor enters his/her name and signature in the space provided. Enter the date when the patient counsel with Adherence Counselor about the medications.
Dispensed by	Pharmacist enters his/her name and signature in the space provided. Enter the date when the medications are dispensed. <b>Note: Must be filled</b>

Picked up by The person who picks up the medications enters his/her name and signature in the space provided. Enter the date of pick up.  
**Note: Must be filled**

## 8. Medication Adherence Assessment Form

Date Enter the date of adherence counseling; started with 2 digits of day, 2 digits of month, and 4 digits of year.  
**Note: Must be filled**

Patient Name Enter patient's surname and other names if any.  
**Note: Must be filled**

Facility Name Enter facility name where the patient is currently enrolled and treated  
**Note: Must be filled**

ID **State:** Enter the state abbreviation in the state boxes.  
**Facility No:** Enter the designated facility number.  
**Serial Enrolment No:** Enter patient's number when s/he was first time enrolled into PEPFAR program.  
**Note: Must be filled**

Hospital No. Enter patient's designated hospital number.  
**Notes:**

- In most case, it is patient's identifying number when s/he first time registered in this hospital/facility.
- Must be filled

1 a. List all current ARV medications and doses missed. Enter the name of medication, dosage and frequency in the column provided. Indicate how many doses missed during yesterday, 2 days ago and 3 days ago.

1 b. List all current TB and OI medications and doses missed. Enter the name of medication, dosage and frequency in the column provided. Indicate how many doses missed during yesterday, 2 days ago and 3 days ago.

2. Many of your medications need to be taken on a schedule, such as "12 hourly" for ARV meds or "once daily" for TB meds. How closely did you follow your specific schedule over the last three days? Indicate how closely patient adheres to his/her taking medications schedule.

3. What do/did you do to help you remember to take/give medications, Indicate what kind of tool or regular event that patient uses to help him/her remember to take his/her medications.

i.e. to be adherent?

4. Sometimes one forgets to take their pills in certain circumstance. Did you/your child skip or miss any of your/his/her medications? Indicate for each time listed in 4a - 4e whether patient misses or skips his/her medications. If the time of patient misses or skips his/her medications, is not listed here, indicate the time in 4f and specify it.
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? Tick **Not applicable/did not miss taking any of medications** if patient never missed his/her medications since the last visit. Tick the check box in **Check all that apply** column any most common reasons for patient not taking or missing his/her medications. Rank top 3 reasons from all reasons that are checked. If the most common reasons are not listed, record them in **Other** and specify them in the space provided.
- 6 a. What issues or barriers need to be addressed for you to become more adherent? Specify. Check issues or barriers that applied. If the issues or barriers are not listed, record them in blank lines provided.
- 6 b. Any other issues? Record any other issues that patient presents.
7. If adherent, continue current treatment strategy as is. If patient adheres, tick Y. Otherwise tick N.
- 8 a. If not adherent, have adherence team re-evaluate patient's situation. Tick Y if patient does not adhere to his/her medication schedule and adherence team will re-evaluate patient's situation. Adherence counselor indicates the next step in regard with patient's re-evaluation in space provided. Otherwise tick N.
- 8b. Suggest the following reminders to help you /your child to take your/his/her medications, i.e., to be adherent. Adherence Counselor tick reminders listed that s/he suggests for patient.

**Adherence Counselor Name** Enter Adherence Counselor's full name.

**Adherence Counselor Signature** Adherence Counselor signs in the space provided.

**Date** Enter the date of counseling.

## 9. Contact Tracking and Termination Form Instruction

This form is filled when the first attempt to contact is started.

ID	<p><b>State:</b> Enter the state abbreviation in the state boxes.</p> <p><b>Facility No:</b> Enter the designated facility number.</p> <p><b>Serial Enrolment No:</b> Enter patient's number when s/he was first time enrolled into PEPFAR program.</p> <p><b>Note: Must be filled</b></p>
Patient Name	<p>Enter patient's surname and other names if any.</p> <p><b>Note: Must be filled</b></p>
Hospital No.	<p>Enter patient's designated hospital number.</p> <p><b>Notes:</b></p> <ul style="list-style-type: none"> <li>- In most case, it is patient's identifying number when s/he first time registered in this hospital/facility.</li> <li>- Must be filled</li> </ul>
1. Patient Contact Address / Ph. Number	Enter patient's contact address and phone number as complete as possible.
2 a. Guardian Name	For paediatric patient Enter child's guardian name.
2 b. Guardian Contact Address / Ph. Number	For paediatric patient Enter guardian's address and phone number as complete and clear as possible.
3 a. Date of Missed Scheduled Appointment	Enter the date of missed scheduled appointment.
3 b. Date of Last Actual Contact	Enter the date of the last time health provider staff or adherence counselor had actual contact with patient.
4. Attempt to Contact	Provide information of attempt to contact. Record the date of contact and who attempts to contact. Indicate mode of communication when attempt to contact. Indicate whether the guardian, CHEW or Peer Supporter are contacted.
Signature of Contact Tracer	Contact Tracer signs in the space provided after last attempted contact made.
Date	Enter the date of last attempted contact.
5. Patient Care Terminated	Indicate whether patient's care is terminated.
6. Reason for exit from program	Indicate whether patient's reason exiting the program is <b>(a) Lost to Follow Up</b> , <b>(b) Dropped Out of Care</b> or <b>(c) Death</b> . If (b) is ticked, specify the specific reason. If (c) is ticked, indicate the date of death and tick the cause of death and specify it.
Date of Termination	Enter the date of termination.
Clinician Name	Enter full name of clinician.
Signature	Clinician signs in the space provided.

**Consultant Name**

Enter the full name of the consultant clinician.

**Consultant Signature**

Enter consultant's signature in the space provided.