

1. Visit Date _____ (dd/mm/yyyy)

2. Patient Name _____

_____ (dd/mm/yyyy)

3. ID - -
State Facility No Serial Enrollment No

4. Hospital No. _____
Other Names

5. Sex F M

6. Date of birth (dd/mm/yyyy) _____

7. Age years If < 5 years months

Please complete both date of birth and age if possible

Medical History

8. Presenting complaint: _____

9. Symptom review:	Y	N	Duration	Y	N	Duration	Y	N	Duration		
Fever	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Ear discharge	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Pain on micturation	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Weight loss/failure to gain weight	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Oral sores	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Genital sores/discharge	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Night sweats	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Cough	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Numbness/tingling	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Irritability	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Convulsion	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Difficulty sleeping	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Food refusal	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Rash	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
Headache	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Diarrhoea	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Itching	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
New Visual Impairment	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Nausea/vomiting	<input type="radio"/>	<input type="radio"/>	<input type="text"/>				

10. Additional comments _____

11 a. Developmental Assessment: please check the most advanced milestone.

- | | | | |
|---|--|--|---|
| Gross Motor: | Fine Motor: | Speech: | Social: |
| <input type="radio"/> Head control | <input type="radio"/> Transfer object hand to hand | <input type="radio"/> Babbles | <input type="radio"/> Smiles responsively |
| <input type="radio"/> Sitting | <input type="radio"/> Pincer grasp | <input type="radio"/> Says mama/dada | <input type="radio"/> Plays with parents |
| <input type="radio"/> Crawling | <input type="radio"/> Ties shoes | <input type="radio"/> Two words together | <input type="radio"/> Plays alone |
| <input type="radio"/> Standing | | <input type="radio"/> Sentences | <input type="radio"/> Plays with other children |
| <input type="radio"/> Walking | | | |
| <input type="radio"/> Able to kick a ball | | | |

11 b. Has the patient lost developmental milestones? Y N If Yes, specify: _____

11 c. Is the child in school? Y N If Yes, provide school name _____

11 d. School performance (1) What class? _____ (2) Satisfactory performance in class? Y N

12 a. Past medical history (including hospitalisation and surgery) _____

12 b. Past drug history/allergies _____

13. Family history _____

14 a. Patient has received previous care for HIV/AIDS from:

- | | |
|--|---|
| <input type="radio"/> None | <input type="radio"/> Self-pay |
| <input type="radio"/> Govt sponsored program | <input type="radio"/> USG sponsored program |
| <input type="radio"/> Mission/faith based | <input type="radio"/> Employer sponsored |

16 a. Mode of Transmission: Unknown

MTCT Other (specify) _____

16 b. Booked for ANC: Y N

If yes, weeks at booking: _____

16 c. Gestational age at birth _____ wks

16 d. Duration of membrane rupture _____ hr _____ min

16 e. Mode of delivery
 vaginal elective Cesarean non-elective Cesarean

16 f. Birthweight _____ grams

16 g. Duration of breast feeding:
 None < 1 month duration
 Currently BF ≥ 1 month duration; Specify # of months: _____

16 h. Was any mixed feeding done? Y N

12 c. Immunisation

- | | | | |
|-----------|--|--|--|
| Birth: | <input type="radio"/> BCG | <input type="radio"/> OPV ⁰ | <input type="radio"/> HBV ₁ |
| 6 weeks: | <input type="radio"/> DPT ¹ | <input type="radio"/> OPV ¹ | <input type="radio"/> HBV ₂ |
| 10 weeks: | <input type="radio"/> DPT ² | <input type="radio"/> OPV ² | |
| 14 weeks: | <input type="radio"/> DPT ³ | <input type="radio"/> OPV ³ | |
| 9 months: | <input type="radio"/> Measles | <input type="radio"/> Yellow fever | <input type="radio"/> HBV ₃ |

14 b. Specify facility name: _____

15. Has the child ever received treatment for an illness by a native doctor/traditional healer/alternative health provider?

Y N

17. Latest CD4 (if available) cells/mL

CD4% %

Date _____ / _____ / _____ Method used: Microscopic

Automated

18 a. Latest VL (if available) c/ml

Date _____ / _____ / _____

Lab records seen (name lab) _____

18 b. Lowest CD4 (if available) counts/mL

CD4% %

Date _____ / _____ / _____ lab records seen

Patient Name

Hospital No

19 a. Previous ARV exposure other than PMTCT (probe)

- None Treatment Months (Specify) _____
 Treatment _____

19 b. Previous ARV exposure through PMTCT

Maternal treatment during pregnancy

- None
 AZT
 NVP
 Other (specify): ____/____/____

Intrapartum PMTCT treatment

- None
 AZT
 NVP
 Other (specify): ____/____/____

Neonatal PMTCT ARV exposure

- None
 AZT
 NVP
 Other (specify): ____/____/____

20. Current medications (probe and specify) None

- ART _____ Other (specify) _____
 TMP/SMX _____ Other (specify) _____
 Anti-TB meds _____ Other (specify) _____

COMPLETE 21, 22, AND 23 ONLY IF PAST HISTORY OF ARV TREATMENT

21. Treatment was interrupted (by patient/caregiver) Y N

Date ____/____/____ Number of days
 Enter code for why patient interrupted medication

22. Treatment was interrupted (by physician) Y N

Date ____/____/____ Number of days
 Enter code for why patient medication was stopped

Reason Codes:

- | | | |
|----------------------------|------------------------|------------------------|
| 1 Felt good | 8 Patient moved | 15 Virologic Failure |
| 2 Forgot/slept through | 9 Toxicity | 16 Immunologic Failure |
| 3 Can't adhere to schedule | 10 Drug interaction | 17 Caregiver travelled |
| 4 Patient refusal | 11 Ran out of medicine | 18 Other |
| 5 Stigma of HIV/AIDS | 12 Med not available | |
| 6 Physician instruction | 13 Not able to Pay | |
| 7 Never went back | 14 Clinical Failure | |

23. ARV Side Effects N/A

- | | | | |
|---|--|--|--|
| <input type="radio"/> None | <input type="radio"/> Pain abdomen or muscle | <input type="radio"/> Liver problems | <input type="radio"/> Tingling of extremities |
| <input type="radio"/> Weakness/fatigue | <input type="radio"/> Diarrhoea | <input type="radio"/> Jaundiced | <input type="radio"/> Rash |
| <input type="radio"/> Headache | <input type="radio"/> Signif. nausea/vomit | <input type="radio"/> Hyperglycemia | <input type="radio"/> Stevens Johnson Syndrome |
| <input type="radio"/> Confusion/dizziness | <input type="radio"/> Pancreatitis | <input type="radio"/> Anaemia | <input type="radio"/> Itching |
| <input type="radio"/> Insomnia/bad dreams | <input type="radio"/> Kidney problems | <input type="radio"/> Fat accumulation or loss | <input type="radio"/> Other (specify) _____ |

24. Physical Exam

(note: NSF= no significant findings)

Temp	°C	BP	/	mm/Hg	Pulse	Weight	kgs	Height/Length	m
Head circumference		cm	MUAC		cm	Weight for height (choose one): <input type="radio"/> normal <input type="radio"/> under <input type="radio"/> over			
General Appearance <input type="radio"/> NSF		Skin <input type="radio"/> NSF		Cardiovascular <input type="radio"/> NSF		Breasts <input type="radio"/> NSF			
<input type="radio"/> Pale <input type="radio"/> Febrile <input type="radio"/> Dehydrated <input type="radio"/> Jaundiced <input type="radio"/> Edematous <input type="radio"/> _____		<input type="radio"/> Pruritic papular dermatitis <input type="radio"/> Scabies <input type="radio"/> Abscesses <input type="radio"/> Herpes zoster <input type="radio"/> Kaposi's lesions <input type="radio"/> Seborrheic dermatitis <input type="radio"/> Fungal infection <input type="radio"/> _____		<input type="radio"/> Irregular pulse <input type="radio"/> Auscultation finding (specify finding) _____ <input type="radio"/> _____		<input type="radio"/> Lumps, masses <input type="radio"/> Tanner stage: _____ <input type="radio"/> _____			
Glands <input type="radio"/> NSF				HEENT <input type="radio"/> NSF		Genitalia <input type="radio"/> NSF			
<input type="radio"/> Parotid swelling <input type="radio"/> Lymphadenopathy <input type="radio"/> _____				<input type="radio"/> Thrush <input type="radio"/> Oral KS <input type="radio"/> Gingivitis <input type="radio"/> Otitis media <input type="radio"/> _____		<input type="radio"/> Ear discharge <input type="radio"/> Oral ulcer <input type="radio"/> _____		Neurological <input type="radio"/> NSF <input type="radio"/> Disoriented in TPP <input type="radio"/> Impaired consciousness <input type="radio"/> Slurred speech <input type="radio"/> Neck stiffness <input type="radio"/> Blindness 1 or 2 eyes <input type="radio"/> Weakness/paralysis <input type="radio"/> Numbness of extremities <input type="radio"/> Fisting/spasticity <input type="radio"/> _____	
Respiratory <input type="radio"/> NSF		Gastrointestinal <input type="radio"/> NSF		Mental status <input type="radio"/> NSF					
rate _____ breaths/min <input type="radio"/> Labored breathing <input type="radio"/> Cyanosis <input type="radio"/> Wheezing <input type="radio"/> Inter/subcostal recession <input type="radio"/> Auscultation finding (specify finding) _____ <input type="radio"/> _____		<input type="radio"/> Hepatomegaly <input type="radio"/> Splenomegaly <input type="radio"/> Tenderness <input type="radio"/> Distention <input type="radio"/> _____		<input type="radio"/> Slow mentation <input type="radio"/> Memory loss <input type="radio"/> Mood swings <input type="radio"/> Depression <input type="radio"/> Anxiety <input type="radio"/> Suicidal ideation <input type="radio"/> _____					

Note: Please review latest lab results

Additional Physical Examination Findings: _____

25. Assessment Asymptomatic Symptomatic AIDS defining illness Opportunistic infections

26. HIV - associated conditions (WHO Paediatric Stage)

- | | | | | | |
|---|---|---------|--|---|---------|
| <ul style="list-style-type: none"> <input type="radio"/> Asymptomatic <input type="radio"/> Persistent generalised lymphadenopathy <input type="radio"/> Hepatosplenomegaly | } | stage 1 | <ul style="list-style-type: none"> <input type="radio"/> Papular pruritic eruptions <input type="radio"/> Seborrheic dermatitis <input type="radio"/> Fungal nail infections <input type="radio"/> Angular cheilitis <input type="radio"/> Lineal gingival erythema <input type="radio"/> Extensive HPV or molluscum infection (>5% of body area/face) <input type="radio"/> Recurrent oral ulcerations (>2 episodes/6 mos) <input type="radio"/> Parotid enlargement <input type="radio"/> Herpes zoster (>1 episode/12 mos) <input type="radio"/> Recurrent or chronic URI: otitis media, otorrhea, sinusitis (>2 episodes/6 mos) | } | stage 2 |
| <ul style="list-style-type: none"> <input type="radio"/> Unexplained moderate malnutrition (-2 SD or Z score) not responding to standard therapy <input type="radio"/> Unexplained persistent diarrhoea (>14 days) <input type="radio"/> Unexplained persistent fever (intermittent or constant, >1 mo) <input type="radio"/> Oral candidiasis (outside neonatal period) <input type="radio"/> Oral hairy leukoplakia <input type="radio"/> Pulmonary tuberculosis <input type="radio"/> Severe recurrent presumed bacterial pneumonia (>2 episodes/12 mos) <input type="radio"/> Acute necrotizing ulcerative gingivitis/periodonitis <input type="radio"/> Lymphoid interstitial pneumonitis (LIP) <input type="radio"/> Unexplained anaemia (<8 gm/dL), neutropenia (<1,000/mm³), or thrombocytopenia (<30,000/mm³) for > 1 mo. <input type="radio"/> HIV-related cardiomypathy <input type="radio"/> HIV-related nephropathy | } | stage 3 | <p>Symptomatic HIV-antibody positive infant age <18 mos, 2 or more of the following:</p> <ul style="list-style-type: none"> <input type="radio"/> Oral candidiasis/thrush <input type="radio"/> Severe pneumonia <input type="radio"/> Failure to thrive <input type="radio"/> Sepsis | } | stage 4 |
| | | | <ul style="list-style-type: none"> <input type="radio"/> Unexplained severe wasting or severe malnutrition <input type="radio"/> Pneumocystis pneumonia <input type="radio"/> Recurrent severe bacterial infections (>2 episodes/12 mos, excluding pneumonia) <input type="radio"/> Chronic orolabial or cutaneous HSV (lasting >1 mo) <input type="radio"/> Extrapulmonary tuberculosis <input type="radio"/> Kaposi's sarcoma <input type="radio"/> Esophageal candidiasis <input type="radio"/> CNS toxoplasmosis <input type="radio"/> Cryptococcal meningitis <input type="radio"/> Any disseminated endemic mycosis <input type="radio"/> Cryptosporidiosis or isosporiasis (with diarrhoea >1 mo) <input type="radio"/> CMV infection of organ other than liver, spleen, lymph nodes (and onset age >1 mo) <input type="radio"/> Disseminated mycobacterial disease other than tuberculosis <input type="radio"/> Candida of trachea, bronchi or lungs <input type="radio"/> Acquired recto-vesico fistula <input type="radio"/> Cerebral or B cell non-Hodgkins lymphoma <input type="radio"/> Progressive multifocal leukoencephalopathy (PML) <input type="radio"/> HIV encephalopathy | } | stage 4 |

27. WHO Stage

28 a. Plan:

28 b. Plan (Order on specific requisition form)

- | | |
|--|--|
| <input type="radio"/> Lab evaluation _____ | <input type="radio"/> OI therapy _____ |
| <input type="radio"/> Screen for tuberculosis _____ | <input type="radio"/> Admission _____ |
| <input type="radio"/> OI Prophylaxis _____ | <input type="radio"/> Symptomatic treatment/pain control (specify) _____ |
| <input type="radio"/> Palliative Care (<input type="radio"/> Psychosocial Support <input type="radio"/> End of Life Care) | <input type="radio"/> CXR _____ |
| <input type="radio"/> Counseling: <input type="radio"/> Adherence <input type="radio"/> VCT | <input type="radio"/> Referrals: <input type="radio"/> Support <input type="radio"/> PMTCT |
| <input type="radio"/> Nutrition <input type="radio"/> Peer Health Support | <input type="radio"/> Other _____ |

29. Enrol in: Follow up ART Pending lab results

