



Paediatric Clinical Evaluation

Initial Visit
 Follow-up Visit

Facility Name: _____

1. Visit Date (dd/mm/yyyy) _____ / _____ /20_____

2. Name _____

Other Names _____

3. ID _____
State Facility No. Serial Enrollment No.

4. Hospital No. _____

5. Presenting complaint:

6. Symptoms in the past month (check all that apply).
 Fever Poor appetite Pain – Legs/feet
 Night sweats Nausea and/or vomiting Numbness or tingling in legs and/or feet
 Fatigue Diarrhoea Low level of developmental milestones
 Weakness Thrush Depression
 Failure to gain weight Pain – Abdominal Other 1 (specify) _____
 Weight loss Rash Other 2 (specify) _____
 Weight gain Cough Other 3 (specify) _____
 Headache Difficulty of breathing Other 3 (specify) _____
 New visual problems Pain – Muscle _____

FOR INITIAL VISIT ONLY
7. Family history / additional comments: _____
8. Past medical problems: _____

9. Previous ARV: **Maternal ARV during pregnancy** **Intrapartum ARV** **Neonatal ARV prophylaxis** **Prior ARV prescription for child** Unknown
 HAART (specify regimen): _____ NVP Single dose NVP
 ZDV only ZDV/3TC None ZDV ZDV x 1 week ZDV x 6 weeks
Specify: _____

FOR FOLLOW UP VISIT ONLY
10. Illnesses since last visit: _____

11. Drug allergies: _____

12. Hospitalization: _____

13. Diet / Feeding: Currently EBF Currently BMS Currently mixed feeding
 Weaned from BF (age at weaning: _____) Nutritional supplement (specify) _____ Regular diet for age

14. Is patient taking: a. Herbal supplement Y N
b. Traditional medicines Y N

15. BIRTH HISTORY, to be completed at INITIAL VISIT ONLY
a. Maternal HIV status: Pos Neg Unknown
b. Duration of membrane rupture (ROM): _____ minutes
c. Delivery: Vaginal C-section
d. Gestation age at birth: _____ weeks f. Birth weight: _____ kg
e. Congenital anomaly: Y N, if yes specify: _____

16. Latest CD4 (if available) _____ Counts/mL
Date _____ / _____ / _____

17. Latest VL (if available) _____ Counts/mL
Date _____ / _____ / _____ Lab records seen

18. Current medications (probe and specify) None
 ART Treatment _____
 TMP/SMX _____
 ART infant PMTCT prophylaxis _____
 Anti-TB meds _____
 Other (specify) _____
 Other (specify) _____

19. Presumed ARV side effects:
Past (if this is initial visit) or Current (if this is follow-up visit).
 N/A Peripheral neuropathy Pancreatitis
 None Rash Fat accumulation or loss
 Significant nausea/vomit Jaundiced Hyperglycemia
 Headache Stevens Johnson syndrome Kidney problems
 Diarrhoea Itching Hepatitis
 Pain abdomen or muscle Anaemia Lactic acidosis
 Insomnia/bad dreams Weakness/fatigue Other (specify) _____
 Confusion/dizzy _____

20. Physical Exam

Temp _____ °C	BP _____ / _____ mm/Hg	Head Circ. _____ cm _____ %		
Pulse _____	Wt _____ kg _____ %	Ht/Lt _____ cm _____ %		
	Normal	Abnormal	Not Done	Comments
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head and Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anorectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify in comments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify in comments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

21. Developmental milestones

	Normal	Delayed	Not evaluated
Cognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Growth motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine motor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. Functional status: Ambulatory Bedridden

23. HIV status: Exposed Baby: Not tested Confirmed HIV infected infant/child
 DNA PCR #1, Date: ___/___/___, Result: Pos Neg Indeterminate
 DNA PCR #2, Date: ___/___/___, Result: Pos Neg Indeterminate

24. WHO staging criteria (History of any of the following) – Past/current if Initial Visit; If Follow-Up Visit, only check new diagnoses since last visit and re-stage if necessary. Complete only if confirmed HIV infection or DNA-PCR not available < 18 months

Stage 1
<input type="checkbox"/> Asymptomatic
<input type="checkbox"/> Persistent generalised lymphadenopathy
<input type="checkbox"/> Hepatosplenomegaly
Stage 2
<input type="checkbox"/> Papular pruritic eruptions
<input type="checkbox"/> Seborrheic dermatitis
<input type="checkbox"/> Fungal nail infections
<input type="checkbox"/> Angular cheilitis
<input type="checkbox"/> Lineal gingival erythema
<input type="checkbox"/> Extensive HPV or molluscum infection (>5% of body area/face)
<input type="checkbox"/> Recurrent oral ulcerations (>2 episodes/6 mos)
<input type="checkbox"/> Parotid enlargement
<input type="checkbox"/> Herpes zoster (>1 episode/12 mos)
<input type="checkbox"/> Recurrent or chronic URI: otitis media, otorrhea, sinusitis (>2 episodes/6 mos)

Stage 3
<input type="checkbox"/> Unexplained moderate malnutrition (-2 SD or Z score) not responding to standard therapy
<input type="checkbox"/> Unexplained persistent diarrhoea (>14 days)
<input type="checkbox"/> Unexplained persistent fever (intermittent or constant, >1 mo)
<input type="checkbox"/> Oral candidiasis (outside neonatal period)
<input type="checkbox"/> Oral hairy leukoplakia
<input type="checkbox"/> Pulmonary tuberculosis
<input type="checkbox"/> Severe recurrent presumed bacterial pneumonia (>2 episodes/12 mos)
<input type="checkbox"/> Acute necrotizing ulcerative gingivitis/periodontitis
<input type="checkbox"/> Unexplained anaemia (<8 gm/dL), neutropenia (<1,000/mm ³), or thrombocytopenia (<30,000/mm ³) for > 1 mo.
<input type="checkbox"/> HIV-related cardiomyopathy
<input type="checkbox"/> HIV-related nephropathy

Stage 4	
Symptomatic HIV-antibody positive infant age <18 mos, 2 or more of the following:	
<input type="checkbox"/> Oral candidiasis/thrush	<input type="checkbox"/> Failure to thrive
<input type="checkbox"/> Severe pneumonia	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Unexplained severe wasting or severe malnutrition	<input type="checkbox"/> Cryptosporidiosis or isosporiasis (with diarrhoea >1 mo)
<input type="checkbox"/> Pneumocystis pneumonia	<input type="checkbox"/> CMV infection of organ other than liver, spleen, lymph nodes (and onset age >1 mo)
<input type="checkbox"/> Recurrent severe bacterial infections (>2 episodes/12 mos, excluding pneumonia)	<input type="checkbox"/> Disseminated mycobacterial disease other than tuberculosis
<input type="checkbox"/> Chronic orolabial or cutaneous HSV (lasting >1 mo)	<input type="checkbox"/> Candida of trachea, bronchi or lungs
<input type="checkbox"/> Extrapulmonary tuberculosis	<input type="checkbox"/> Acquired recto-vesico fistula
<input type="checkbox"/> Kaposi's sarcoma	<input type="checkbox"/> Cerebral or B cell non-Hodgkins lymphoma
<input type="checkbox"/> Esophageal candidiasis	<input type="checkbox"/> Progressive multifocal leukoencephalopathy (PML)
<input type="checkbox"/> CNS toxoplasmosis	<input type="checkbox"/> HIV encephalopathy
<input type="checkbox"/> Cryptococcal meningitis	
<input type="checkbox"/> Any disseminated endemic mycosis	

25. Only complete at Initial Visit or if change to more advanced WHO stage at Follow Up Visit.

26. Immunization:

Up to date Incomplete
 Vaccination needed _____

27. TB Status: No signs or symptoms suggesting TB Sputum sample sent - date, sputum results and date received
 Currently on INH prophylaxis, dose, adherence Currently on TB treatment → Duration _____
 Suspected TB, referred for evaluation (include referral date) Prior history of treated TB

28. Assessment and Plan

29. List all medication being started, stopped or continued:

Medication	Recommendation			Reasons for Discontinuation*	Dose and Comments
	Start	Stop	Continue		
Zidovudine (AZT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lamivudine (3TC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stavudine (D4T)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Didanosine (DDI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Abacavir (ABC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nevirapine (NVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Efavirenz (EFV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nelfinavir (NFV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kaletra (LPV/r)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ritonavir (RTV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Saquinavir (SQV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
TMP/SMX (Cotrimoxazole)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rifampicin (RIF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Isoniazid (INH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

* Reason for discontinuation:
1 = Side effect / Toxicity / Drug interaction 3 = Patient non-adherence 5 = PMTCT prophylaxis complete
2 = Disruption in drug supply / Stock out 4 = Treatment failure 6 = Patient refused
7 = Other, specify _____

30. What referrals will be made for the patient
 None In-patient care / Hospitalization Family counseling Clean water Other referral (specify) _____
 Family planning services TB treatment / DOT program Social support services Insecticide treated nets _____
 Nutritional support Adherence counseling Home-based care _____

31. When is the patient's next appointment? 1 week 2 weeks 4 weeks 2 months 3 months → _____ / _____ /20

Clinician Signature _____ Print Name _____