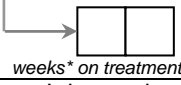
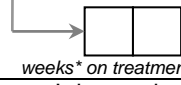
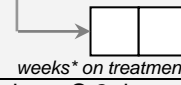
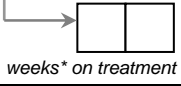




Antiretroviral Indicate which ARVs were used – add comments as needed	Maternal Use			Infant Use
	Antepartum	Intrapartum	Postpartum while breast feeding	Perinatal prophylaxis
Other (specify):	<input type="radio"/> yes, 1 dose only <input type="radio"/> yes, ≥ 2 doses  weeks* on treatment	<input type="radio"/> yes <input type="radio"/> no	<input type="radio"/> yes, 1 dose only <input type="radio"/> yes, ≥ 2 doses  weeks* on treatment	<input type="radio"/> 1 dose <input type="radio"/> 2 doses <input type="radio"/> ≥ 2 doses  weeks* on treatment
Other (specify):	<input type="radio"/> yes, 1 dose only <input type="radio"/> yes, ≥ 2 doses  weeks* on treatment	<input type="radio"/> yes <input type="radio"/> no	<input type="radio"/> yes, 1 dose only <input type="radio"/> yes, ≥ 2 doses  weeks* on treatment	<input type="radio"/> 1 dose <input type="radio"/> 2 doses <input type="radio"/> ≥ 2 doses  weeks* on treatment

* Enter 01 if ≥ 2 doses but less than one week. Round to highest week for all others. Leave blank if < 2 doses given.

10. Is the child currently being breastfed? Yes No

10a. If yes, is the child receiving any foods or liquids other than breastmilk (including water)? Yes No

11. Within the last month, has the patient experienced any of the following symptoms? Yes No

If yes, fill in the 'o' to the right of each condition. If no, proceed to question 12.

Symptom	Yes	Symptom	Yes
Cough	<input type="radio"/>	Numbness or tingling in legs and/or feet	<input type="radio"/>
Depression	<input type="radio"/>	Pain - Abdominal	<input type="radio"/>
Diarrhea	<input type="radio"/>	Pain - Muscles	<input type="radio"/>
Difficulty breathing	<input type="radio"/>	Pain - Legs/feet	<input type="radio"/>
Fatigue	<input type="radio"/>	Poor appetite/ poor feeding	<input type="radio"/>
Fever	<input type="radio"/>	Rash	<input type="radio"/>
Headache	<input type="radio"/>	Thrush	<input type="radio"/>
Learning/education problems (if applicable)	<input type="radio"/>	Weakness	<input type="radio"/>
Memory problems	<input type="radio"/>	Weight loss / failure to thrive	<input type="radio"/>
Nausea and/or vomiting	<input type="radio"/>	Other 1 (specify):	<input type="radio"/>
New visual problems	<input type="radio"/>	Other 2 (specify):	<input type="radio"/>
Night sweats	<input type="radio"/>	Other 3 (specify):	<input type="radio"/>

12. Physical examination

Temperature . °C Length/ Height cm Weight . kg Head Circumference . cm

Examinations	Normal	Abnormal	Not Done	Comments / Descriptions
Ears, nose, throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Head and neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cardiovascular	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lungs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lymph nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Urogenital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Musculoskeletal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Neurological	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Developmental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Tanner staging (if applicable)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other 1 (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

13. Does the patient meet appropriate developmental milestones? Yes No

See [Clinical Manual](#) for developmental milestones

14. What is the result of the patient's HIV test?

No HIV test has been done

A DNA PCR test was done and was: Positive Negative

Date: / /

A RNA PCR test was done and was: Positive Negative

Date: / /

If positive, the number of copies was: _____

An HIV antibody test was done and was: Positive Negative

Date: / /

15. If HIV-infected, what is the patient's most recent CD4 count?

/mm³ % / / date specimen collected

16. If HIV-infected, what is the patient's current WHO clinical stage?

WHO stage I WHO stage II WHO stage III

WHO stage I*	WHO stage II*	WHO stage III*
<ul style="list-style-type: none"> ▪ Asymptomatic ▪ Generalized lymphadenopathy 	<ul style="list-style-type: none"> ▪ Unexplained chronic diarrhea ▪ Severe persistent or recurrent candidiasis outside the neonatal period ▪ Weight loss or failure to thrive ▪ Persistent fever ▪ Recurrent severe bacterial infections 	<ul style="list-style-type: none"> ▪ AIDS-defining opportunistic infection ▪ Severe failure to thrive ▪ Progressive encephalopathy ▪ Malignancy ▪ Recurrent septicaemia or meningitis

* use locally modified staging where appropriate

17. What medications is the patient currently taking? None

- Isoniazid (INH) preventive therapy
- Treatment for active TB disease
- Other (please list all prescription, nonprescription, herbal, complementary, and traditional agents):
- Cotrimoxazole prophylaxis
- Antiretroviral treatment (ART): please specify

18. Has the patient previously been treated for tuberculosis? Yes No

If yes, please specify when treated and with which drugs:

19. Has the patient previously been treated with antiretroviral medication?

(Do not include perinatal prophylaxis, which should be recorded in question 9)

- No
- Yes, patient was previously treated with antiretroviral medications (ART). Please specify when treated and with which drugs:

20. If not on OI prophylaxis, indicate eligibility for OI prophylaxis as of this visit:

Not yet determined/ awaiting other information

Ineligible

Eligible →

Eligible for prophylaxis by CD4 count → CD4 count = CD4%:

CD4 specimen date: / /

Eligible for prophylaxis because < 12 months of age

Eligible for prophylaxis because of WHO stage → WHO Stage =

Other (specify): _____

21. If not on antiretroviral treatment (ART), indicate eligibility for ART as of this visit:

Not yet determined/ awaiting other information

Ineligible

Eligible →

Eligible for ART by CD4 count → CD4 count = CD4%:

CD4 specimen date: / /

Eligible for ART by WHO Stage → WHO Stage =

Other (specify): _____

22. List all medications being started, stopped, or continued:

Medication	Recommendation			Reasons for Stopping Meds*	Dose and Comments
	Start	Stop	Continue		
Cotrimoxazole	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Dapsone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Zidovudine (AZT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Lamivudine (3TC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Stavudine (D4T)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Didanosine (DDI)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Abacavir (ABC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Nevirapine (NVP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Efavirenz (EFV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Nelfinavir (NFV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Lopinavir/ritonavir (LPV/r)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Tenofovir (TDF)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Isoniazid (INH):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Rifampin (RIF):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Ethambutol (ETH):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Pyrazinamide (PZA):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Streptomycin (STREP):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

* Reasons for Stopping Medication:

1 = Side Effect / Toxicity / Drug interaction
2 = Disruption in Drug Supply / Stock out

3 = Patient non-adherence
4 = Treatment failure

5 = pMTCT prophylaxis complete
6 = Patient refused

7 = Other, specify

23. Has the patient received any immunizations? Yes No

If yes, fill in 'o' for all that apply; leave total number of doses column blank if unknown.

Vaccine	Yes	Total number of doses received before enrollment		Vaccine	Yes	Total number of doses received before enrollment	
BCG	<input type="radio"/>			Measles	<input type="radio"/>		
HBV	<input type="radio"/>			Yellow Fever	<input type="radio"/>		
DPT	<input type="radio"/>			Other 1 (specify):	<input type="radio"/>		
OPV	<input type="radio"/>			Other 2 (specify):	<input type="radio"/>		

24. Patient Plan: _____

25. What tests will be ordered for the patient?

Fill in 'o' for all that apply:

- None
- Complete Blood Count
- CD4 Count
- ALT (Alanine Aminotransferase)
- AST (Aspartate Aminotransferase)
- Creatinine
- Electrolytes
- Tuberculin skin test (TST using PPD)
- Sputum for AFB
- HIV DNA PCR
- HIV RNA PCR
- HIV antibody test
- Radiology test (specify): _____
- Other (specify): _____

26. What referrals will be made for the patient?

Fill in 'o' for all that apply:

- None
- Nutritional support
- Psychosocial counseling
- In-patient care / Hospitalization
- TB treatment / DOT program
- Adherence counseling
- Mental health services
- Social support services
- Other referral (specify): _____

27. When is the patient's next appointment?

- 1 week
- 1 month
- 2 months
- 3 months
- 6 months
- Other (specify): _____

] → Appointment Date: / /
 day month year

Completed By: _____ Provider Initials: