USAID FROM THE AMERICAN PEOPLE — ampath PLUS

Pediatric Initial Encounter Form v5.02

Date / /

First name	Middle name	Last name
AMRSID:	☐☐☐☐☐☐☐☐☐☐ – ☐	**Unique patient ID(*GOK*):**
AMPATH ID:	**Phone Number:**	**TB registration ID:**
Date of Birth:_____/____/_______	**If Birth date Unknown, Age at last Birthday:**	**Sex:** ☐ M ☐ F
Tribe:	**County :**	**District:**
Location:	**Sub-location:**	**Landmark:**
Nearest H/Facility :	**Postal address:**	

Child referred from: ☐ pMTCT ☐ MCH ☐ Inpatient ☐ POPC ☐ DTC/PITC ***(AMPATH)*** ☐ VCT ☐ PHCT ☐ TB Clinic ☐ OPD ☐ Other:

1.Site / Satellite Clinic ***(Required)***: **Module # *(If applicable)*** ☐ 1 ☐ 2 ☐ 3 ☐ 4

2. Vitals:	**RR** ________ **breaths/min** **Wt** _________**kg**	**Pulse**_______ **beats/min** **Height** ________ **cm**	**Temp[C°]**_________ **Head Circ.**________ **cm(<=2yrs)**	**SaO$_2$**______**%** **BP** _________**/**________

3. AMPATH Catchement area ☐ In Catchment ☐ Out of Catchment

4.Source of prior HIV care and treatment : ☐ None ☐ Other Program:

5.Transfer In care from other facility ***(specify)***: District:

6.Date started HIV care / / ***(dd/mm/yyyy)***

7.Person Bringing Patient Today: ☐ Mother ☐ Father ☐ Sibling ☐ Grandparent (☐Paternal ☐Maternal) ☐ Friend ☐ Self ☐ Auntie (☐Paternal ☐Maternal) ☐ Uncle (☐Paternal ☐Maternal) ☐ Children's Home ☐ Neighbor ☐ Other:

8. Family Information *(Parents, Siblings, Primary Caretaker)*

Parental Information:	**Mother**	**Father**
8a. Name:		
8b. If applicable, AMRS/AMPATH ID:	☐☐☐☐☐☐☐☐☐ – ☐	☐☐☐☐☐☐☐☐☐ – ☐
8c. If applicable: Unique Patient ID ***(GOK):***		
8d. Deceased	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
8e. If Deceased, HIV as cause of Death	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
8f. If Alive, are they absent	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
8g. Aware of child's HIV status	☐Yes ☐ No ☐ Unknown ☐ N/A	☐ Yes ☐ No ☐ Unknown ☐ N/A
8h. If Alive, HIV Status:	☐ HIVpos ☐ HIVneg ☐ Unknown	☐ HIVpos ☐ HIVneg ☐ Unknown
8i. If HIV+, enrolled in care	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
8j. If HIV+, on ARVs	☐ Yes ☐ No ☐ Unknown ☐ N/A	☐ Yes ☐ No ☐ Unknown ☐ N/A
8k. On anti-TB meds	☐ Yes ☐ No ☐ Unknown ☐ N/A	☐ Yes ☐ No ☐ Unknown ☐ N/A
8l. Opportunistic Infection ***(OI)*** Prophylaxis	☐ Yes ☐ No ☐ Unknown ☐ N/A	☐ Yes ☐ No ☐ Unknown ☐ N/A
8m. Patient covered by NHIF	☐ Yes ☐ No (***if NO for NHIF, refer to social work***)	

8n.Siblings ***(and guardian if applicable)***:

Age	**Relation**	**Deceased**	**HIV Status**	**In care**	**Unique patient ID(*GOK*):**	**AMPATH/AMRS ID:**
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		
		☐Yes ☐No	☐Pos ☐Neg ☐Unkn	☐Yes ☐No		

8o. Child living with(***tick all that apply)***: ☐ Mother ☐ Father ☐ Foster parents ☐ Neighbor ☐ Sibling ☐ Children's Home ☐ Grandparent (☐ Paternal ☐ Maternal) ☐ Auntie/Uncle (☐ Paternal ☐ Maternal) ☐ Other ____

8p. If parents***(mother or father)*** absent Guardian's Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ N/A ☐ Other ***(Specify)***:

9.General History

9a. Child's Current HIV Status: ☐ **HIV exposed, status indeterminate** ☐ **HIV infected** ☐ **HIV negative**

9b. If HIV+: Child aware of own HIV status: ☐ Not disclosed ***(child with good cognition normally > 7-10yrs)*** ☐ Partially disclosed ☐ Disclosure completed ☐ Acceptance of diagnosis, management ongoing ☐ Unknown ☐ N/A ***(child with poor cognition normally < 7-10yrs)***

10. Birth History:

10a. Birth weight ___.___ ___ kg or Earliest Weight___. ____kg at _____age in weeks □ Unknown
10b. Method of Delivery: □ Vertex Delivery □ Spontaneous Vaginal Delivery □ C-section □ Breech
□ Other_____ □ Unknown Assisted: □ Vacuum □ Forceps

10c. Prematurity ***(EGA < 36weeks)*** □ Yes □ No □Unknown **10d.** Episiotomy done on mother □ Yes □ No □Unknown
10e. ROM > 4 hours □ Yes □ No □Unknown **10f.** Obvious birth defects □ Yes □ No
10g. If yes, for obvious birth defects ***(specify)*** :
10h. Did the child receive ARV's during infancy for perinatal prophylaxis □ Yes □ No □ Unknown

10i. ***If yes, fill in box next to ARV(s) received by the infant***

Antiretroviral	Amount received	Duration Specify
Nevirapine (NVP)	□ 1 dose □ 2 doses □ >2 doses	Days _____weeks _____months_____
Zidovudine (AZT)	Number of days given _____	weeks _____
Lamivudine (3TC)	Number of days given _____	weeks _____
Other ***(Specify)***	□ 1 dose □ 2 doses □ >2 doses	Days _____ weeks _____

10j. Did the patient's mother receive ARV***(s)*** during pregnancy □ Yes □ No □ Unknown
10k. If yes, then indicate dosing period □ Antepartum □ Intrapartum □ Postpartum

Antiretroviral	Duration Specify	Antiretroviral	Duration Specify
□ Single dose Nevirapine	weeks_____	□ Zidovudine	weeks_____
□ lamivudine	weeks_____	□ Triple therapy :	weeks_____

10l. Previous Immunizations: □ None □ Completed Schedule

□ BCG	□ Polio 0			
□ Penta 1	□ Polio 1	□ PCV 1	□ Rotavirus 1	□ Vitamin A ***(children under five only)***
□ Penta 2	□ Polio 2	□ PCV 2	□ Rotavirus 2 ***(given before 6 months)***	
□ Penta 3	□ Polio 3	□ PCV 3	□ Measles 0 ***(6months)***	□ Measles ***(9months)***

10m.Immunizations confirmed from card □ Yes □ No

11. Feeding History for Children < 2 years of age ***(tick all that apply) (if >2 years move to12)***

11a. What did the child feed on or drink in the last 24 hrs □ Breast □ Expressed Breast milk □ Cow's/Animal milk □ Formula □ Water □ Solid food **(ugali, potatoes, bananas)** □ Other Liquids ***(uji, tea)***
11b. If Breast Feeding, has mother been counseled on feeding techniques, problems and solutions □ Yes □ No
11c. Has the child ever breast-fed in the past. □ Yes □ No If yes, for how long _____
11d. What is the mother is feeding choice/s for the infant □ Breast □ Expressed Breast milk □ Formula □ Cow's/Animal milk □ Water □ Other Liquids ***(uji, tea)*** □ Solid food ***(ugali, potatoes, bananas)***
11e. Is mother currently taking Antiretrovirals: □ Yes □ No □ Unknown If Yes, List:
11f. if using formula, has mother/caretaker, been counseled on IYCF/milk Preparation □ Yes □ No ***(if no, refer to Nutrition for counseling)***
11g. If using formula, does the mother/caregiver feel competent in preparing it □ Yes □ No ***(if no, refer to Nutrition for counseling)***
11h. Has child been completely weaned □ Yes □ No if yes, age at complete weaning_____***(months)***

12. Education

12a. Has the child ever attended school □ Yes □ No □ Not applicable ***(child not of school age(6yrs))***
12b. If yes for **12a**, Is the child currently attending school □ Yes □ No ***(If no, refer for social work assessment)***

13. Adolescent ***(12 -19 yrs)*** **13a.** Are you sexually active □ Yes □ No **13b.** If yes, are you using condoms □ Yes □ No
Comments:

14. Review of Systems

14a. Chief Complaint □ None □ Having Symptoms

14b. General: □ No complaints
□ Fever □ Rash □ Weight loss □ Poor weight gain □ Lethargy/irritability
□ Fatigue □ Jaundice □ Major congenital abnormality □ Night Sweats □ Pain (specify):_____
□ Swelling **Swelling Location:** □ Neck □ Armpit □ Abdomen □ Joints □ Edema of legs
□ Other _____Comments:

14c. HEENT: □ No complaints
□ Oral Thrush □ Mouth Sores □ Swelling ***(specify):***_____ □ Swallowing difficulties
□ Vision difficulties/eye discharge □ Ear discharge □ Nasal Discharge □ Pain ***(specify):*** _____
Comments:

14d. Cardiopulmonary : □ No complaints
□ Cough O days O weeks O months □ Rapid breathing O days O weeks O months
□ Cough productive O white O purulent O blood □ Pneumonia in the past
□ SOB O days O weeks O months Comments:
SOB: □ At rest □ On exertion
Comments:

14e. Gastrointestinal : □ No complaints
□ Poor appetite □ Refusal to feed O days O weeks O months
□ Abdominal pain □ Abdominal Swelling □ Vomiting O days O weeks O months O Continuous
□ Hx of jaundice □ Diarrhea O days O weeks O months O Continuous
Comments:

14f. Genitourinary: □ No complaints
□ Dysuria □ Hematuria □ Oliguria □ UTI in the past □ Renal Disease
□ Urethral Discharge O days O weeks O months
□ History of sexual abuse If yes, how long ago _____ ***(this will not be entered in AMRS)***
Comments:

14g. Musculoskeletal : □ No complaints
□ Joint pains □ Swelling of joints □ Muscle pain □ Pain in the legs/feet □ Spine swelling
Comments:

14h. Psychiatric Review : □ No complaints
□ Feeling low □ Confusion □ Suicidal □ Memory problems □ Anxiety □ Over-excited □ Abnormal behavior
Comments:

14i. Developmental : □ No complaints
□ Delayed milestones □ Regressed milestones □ Memory Problems □ Learning or educational problems
Comments:

15. Hospitalizations

15a. Has the patient been hospitalized in the previous year □ Yes □ No
15b. If yes, how many hospitalizations did the patient have in the past year
15c. State the diagnosis (es) leading to hospitalization: 1. _____ 2. _____
3. _____ 4. _____

Medication History

16. Allergies

Drug:	Allergy:	Reaction:
16a. Penicillin	□ Yes □ No	□Rash □Itching □Wheezing □Swelling □Vomiting □ Other:
16b. Sulfa	□ Yes □ No	□Rash □Itching □Wheezing □Swelling □Vomiting □ Other:
16c. Other:	□ Yes □ No	□Rash □Itching □Wheezing □Swelling □Vomiting □ Other:
16d. Other:	□ Yes □ No	□Rash □Itching □Wheezing □Swelling □Vomiting □ Other:

17. Antiretroviral medications

17a. Is the patient ***currently*** taking any of the following antiretroviral medications □ Yes □ No **17b**. Date Started: _____/____/_____
(Do not include perinatal prophylaxis medications reported inQ9h.)
17c. Treatment categories : □ First line □ Second line ***(following viral failure)*** □ Third line ***(Salvage regimen)*** *(Tick all that apply below)*

17d. Current ARV Drugs :

□ Abacavir/Lamivudine **(ABC60 / 3TC30)**
□ Zidovudine/Lamivudine**(ZDV60/3TC30)**
□ Zidovudine/lamivudine/Nevirapine **(ZDV60 / 3TC30 / NVP50)**
□ Zidovudine/lamivudine/Nevirapine **(ZDV300 / 3TC150 / NVP200) > 25kgs**
□ Nevirapine(NVP) _____ **mg /** _____**ml**
□ Efavirenz (EFV) _____ **mg /** _____**ml**
□ Lamivudine (3TC)____ **mg / __ml**
□ Abacavir (ABC) _____**mg / ____ml**
□ Stavudine/Lamivudine/Nevirapine **(d4T12 / 3TC60 / NVP100)T-jr**
□ Stavudine/Lamivudine/Nevirapine **(d4T30 / 3TC150 / NVP200) > 25kgs**
□ Zidovudine/Lamivudine **(ZDV300/3TC150) >25kgs**
□ Stavudine/Lamivudine **(D4T30/ 3TC150)>25kgs**
□ Tenofovir / Lamivudine **(TDF300 / 3TC300) > 25kgs**
□ Tenofovir/Lamivudine/ Efavirenz **(TDF200/ 3TC600/ EFV300) > 25kgs**
□ Lopinavir / Ritonavir _____**ml**
□ Lopinavir / Ritonavir _____**tabs (LPV200/ RIT50)>25kgs**
□ Zidovudine (ZDV or AZT) **_mg / __ml**
□ Ritonavir**(Rit100)**____**tabs**
□ Ritonavir _____**mg (Norvir sec100)**
□ Ritonavir____**mg**____**ml (Norvir80)**
□ Atazanavir/Ritonavir **(Atazanavir300/ritonavir100)**
□ Didanosine(DDI) __**mg**
□ Raltegravir ___**mg**
□ Darunavir
□ Atazanavir
□ Unknown name
□ Other :

18a. Has the patient used any antiretroviral medications in the ***past*** (other than those ticked in **17d**) □ Yes □ No
(Do not include perinatal prophylaxis medications reported inQ10h.) **18b.** Date Started: _____/____/_____**18c.** Date Stopped : _____/____/_____
18d. Past treatment categories : □ First line □ Second line ***(following viral failure)*** □ Third line ***(Salvage regimen)***

18e. Past ARV Drugs :

19. Anti-Tuberculosis Screening and Medications

19a. Since last visit have you had any of the following? ***(tick all that apply)*** □ None □ Cough for more than 2 weeks
□ History of close contact with confirmed TB or chronic cough □ History of fever or illness for more than 2 weeks
□ Low weight for age or failure to thrive Swelling : □ neck □ armpit □ abdomen □ joints □ groin***(Swollen lymphnode*****s)**
(If any of the above is checked, examine the child and then use the pediatric TB Intensified Case Findings chart to further evaluate. Refer when If None , stop investigations and skip to question 19h. Repeat screening at subsequent visits.)

19b. If patient diagnosed, TB Diagnosis done on basis of: **(Action taken) ***

Investigations : □ Suggestive CXR □ AAFB positive □ TST positive
Criteria : □ New GOK *(Year 2011)* □ Keith Jones score:_____ □ Edward Keith score:_____ □ Other specify:_____ ***(For scoring Check criteria on pediatric manual)****

19c. Referral outcome □ TB □ No TB

19d. History of TB Rx: □ Currently on treatment***(active)*** ***if on move to 19d*** □ Treatment completed **(inactive)** _____**(Year completed)**

19e. Tuberculosis Treatment Phase : □ Intensive/initiation □ Continuation

19f.TB Meds:			
□ Rifafour(RHZE) ____tabs/day	□ Rifinah(RH) ____tabs/day	□ INH_____mg	□ MDR TB Drugs
□ Rifater(RHZ)____tabs/day	□ Ethizide(EH) _____mg	□ Pyrazinamide _____mg	***(Cycloserine,Protionamide,Capreomycin,Kanamycin, P.A.S, Levofloxasin,Pyridoxine)***
□ Ethambutol _____mg/day	□ Rifampicin_____mg	□ Rifabutin_____mg	□ Other:
□ Streptomycin_____mg	□ 3-FDC(RHE)____tabs/day		□ Completed (Date:____/____/_____)

19g. If on TB treatment, site of TB meds pick-up: □ This AMPATH site □ Other ***(specify):***

19h.TB Prophylaxis: □ None □ Isoniazid 100mg □ Isoniazid 300mg | **19i.** If on TB prophylaxis start date ____/____/_____

19j. Opportunistic Infection***(OI)*** Prophylaxis : □ None □ Cotrimoxazole ***(Septrin)*** □ Dapsone □ Fluconazole _____mg ***(Diflucan)***

19k. Other medications :

□ Anti-fungal***(specify):***_____	□ Herbal /traditional medications
□ Minerals / iron supplements	□ Anti-Diabetes***(specify)*** :_____
□ Antibiotic***(specify)***:_____	□ Anticancer***(specify)*** :_____
□ Anti-Hypertensive (***specify)*** :_____	□ Other ***(specify)***:_____

20a. Side-effects/Toxicity: Any side effects attributable to any drug that the child is ***currently taking*** □ Yes □ No
If Yes, drug(s) **:**_____

20b. If yes, tick all that apply**:**	□ Rash	□ Anemia	□ Lipo-dystrophy	□ Hepatitis	□ Neuropathy	□ IRIS
	□ Lactic Acidosis	□ Diarrhea	□ Steven-Johnson syndrome	□ Persistent Vomiting		
	□Other (specify):					

20c. Any side effects attributable to any drug that the child has ***ever taken*** □ Yes □ No
If Yes drug(s) *:*_____

20d. If yes, indicate the reaction***(s)(use the responses in 20 b above)*****:** _____
_____

20e. Severity of the reaction:	□ Mild	□ Moderate	□ Severe	□ Unknown	□ Other ***(specify):***
20f. Cause of the reaction/toxicity:	□ Certain	□ Probable/Likely	□ Possible	□ Unlikely	□ Conditional/Unclassified
	□ Unassessable/Unclassified				

20g. Disability: □ Yes □ No **20h.**If Yes: □ Cerebral Palsy □ Physical_____ □ Mental _____
20h. Does the child have growth faltering/FTT □ Yes □ No **(*If Yes, refer to nutritionist*)**
20i. Is the child overweight □ Yes □ No **(*If Yes, refer to nutritionist*)**

21. Assessment of Congenital abnormalities

21a. Any congenital abnormality □ Yes □ No ***If yes, categorize abnormality below*** ***If No, move to question 22***

21b. Central Nervous System ***(CNS):*** □ Hydrocephalus □ Neural tube defects
□ Other***(specify)***:

21c. Eye, Ear, Face and Neck : □ Cleft lip and palate
□ Other***(specify)***:

21d. Heart : □ Acyanotic defects ***(ASD, VSD, AV canal, PDA, etc)*** □ Cyanotic defects ***(e.g. Tetralogy of Fallot, transposition, pulmonary atresia, truncus,Ebstein's)***
□ Other or Specify based on Echo:

21f. Gastro-intestinal system : □ Gastroschisis □ Intestinal atresia □ Tracheo-esophageal Fistula □ Omphalocele
□ Anorectal malformation □ Other:

21g. Genitals : □ Ambiguous genitalia □ Hypospadias □ Other:

21h. Renal and urinary system : □ Posterior Urethral valves □ Other:

21i. Limb defects : □ Talipes equinovarus ***(club foot)*** □ Other:

21j. Chromosomal anomaly : □ Downs syndrome □ Other:

21k. □ Other Organ systems, or multi-organ system : ***(specify)***:

Examination findings : ***If abnormal, check all that apply under each exam finding***

22. General Exam: □ Normal □ Abnormal
□ Gluteal Wasting □ Angular Cheilitis □ Pallor □ Jaundice □ Oedema □ cyanosis
□ Signs of physical abuse ***(specify)***:_____
Comments:

23. Skin Exam: □ Normal □ Abnormal
□ Herpes simplex □ Rash □ Septic Spots □ Kaposi's sarcoma □ Swelling □ Abscess
Comments:

24. Lymph Nodes Exam: □ Normal □ Abnormal
□ submandibular □ cervical □ supraclavicular □ axillary □ inguinal
Comments:

25.HEENT Exam: □ Normal □ Abnormal
Eyes: □ Sclera icteric □ Conjunctiva pale □ Fundal abnormality □ Eye discharge
Ears: □ Ear discharge □ Tympanic Membrane injected
Neck: □ Trachea deviated □ Nuchal rigidity □ Parotid enlargement
Oropharynx: □ Cleft Palate □ Oral Sores ***(Aphthous)*** □ Tonsillar enlargement □ Kaposi sarcoma
□ Significant dental caries □ Thrush
Nose: □ Purulent discharge
Comments:

26. Respiratory Exam: □ Normal □ Abnormal
Percussion : □ Dullness O Left O Right
Auscultation : □ Breath sounds diminished □ Bronchial breath sounds Location _____
□ Rhonchi □ Crepitations Location _____
Comments:

27. CVS Exam: □ Normal □ Abnormal □ Evidence for enlargement □ LV lift □ RV lift
□ Abnormal Sounds □ S_3 Gallop □ Pericardial friction rub □ Diastolic Decrescendo
□ Murmurs ***(specify)***: □ Systolic Ejection Murmur □ Holosystolic Murmur □ Diastolic Rumble
Comments:

28. Abdominal Exam: □ Normal □ Abnormal
□ Tender to palpation Location_____ □ Ascites □ Mass □ Distended
□ Hepatomegaly _____ ***(cm below costal margin)*** □ Splenomegaly _____ ***(cm below costal margin)***
Comments:

29. Extremities Exam: □ Normal □ Abnormal
□ Edema □ Leg ulcers □ Cellulitis □ Rickets □ Kaposi sarcoma
Comments:

30. Musculoskeletal Exam: □ Normal □ Abnormal
□ Joint swelling □ Spine swelling □ Muscle tenderness
Comments:

31. Neurologic Exam: □ Normal □ Abnormal
□ Irritable □ Altered mental status □ Cranial nerve abnormality □ Tone abnormal
□ Abnormal movements/seizures □ Focal weakness □ Deep tendon reflexes asymmetric
Comments:

32. Psychiatric : Exam □ Normal □ Abnormal
□ Feeling low □ Confusion □ Suicidal □ Memory problems □ Anxiety □Over-excited □ Abnormal behavior
Comments:

33. Developmental Exam: □ Normal □ Abnormal
Does not meet age appropriate milestones ***(specify)*** : □ Regressed □ Delayed
□Tanner Staging : O Normal O Abnormal O Not done Stage: _____
Comments:

34. Urogenital □ Normal □ Abnormal ***(check for sexual abuse signs)***
□ Signs of Sexual Abuse □ Genital ulcers □ Warts
Comments:

35.Test	**Result**	**Test Date**
WBC/mm^3		
Hgb g/dL		
MCV		
Platelets/ mm^3		
ALC/ mm^3		
SGPT(ALT) u/l		
Creatinine mmol/L		
CD4		
CD4%		
CXR	**Code :**	

code : 0=normal 1=Pl Effusion 2=Infiltrate 3=milliary 5=cavitary 4=Diffuse abn/non-milliary 6 = Cardiomegaly 7=other abnormality
(specify)_____
_____

Test	**Result**	**Test Date**
Sputum AFB Smear		
Sputum Xpert: MTB		
RIF		
Sputum Culture		
TST ***(Mantoux test)***		
1st HIV DNA PCR		
2nd HIV DNA PCR ***(Post Weaning)***		
HIV Rapid Elisa		
HIV Long ELISA		
Viral Load		
Other		
Other		

36. Does the patient currently have, or has the patient ever had, any of the following conditions

WHO Stage : ***Fill in the appropriate box next to each indicator condition***
NoteA Patient should remain in the worst stage ever even if they have improved health wise.***

STAGE 1	
□	□ No symptoms and no signs □ Persistent generalized lymphadenopathy
STAGE 2	
□	□ Unexplained persistent hepatomegaly and splenomegaly □ Unexplained persistent parotid gland enlargement □ Recurrent oral ulcerations □ Papular pruritic skin erruptions □ Fungal nail infections □ Lineal gingival erythema □ Extensive Molluscum contagiousum □ Herpes zoster □ Extensive wart virus infection □ Recurrent or chronic upper respiratory tract infections (otitis media, otorrhoea, sinusitis or tonsillitis)
STAGE 3	
□	□ Unexplained moderate malnutrition not adequately responding to standard therapy □ Persistent diarrhoea (14 or more days) □ Unexplained persistent fever (above 37.5c intermittent or constant, for longer than one month) □ Persistent Oral candidosis (outside 6-8 weeks of life) □ Oral hairy leukoplakia □ Lymph node tuberculosis □ Pulmonary tuberculosis □ Recurrent severe bacterial pneumonia □ Acute necrotizing ulcerative gingivitis, or periodontitis □ Symptomatic lymphoid interstitial pneumonitis □ Chronic HIV-associated lung disease including brochiectasis □ Unexplained anemia (<8 g/dl), neutropenia ((<500/mm3) or <0.5 X 10^9 per L)), and/or chronic thrombocytopenia ((<50,000/mm3) or <50 X 10^9 per L)
STAGE 4 *(AIDS)*:	
□	□ Unexplained Severe wasting, stunting or sever malnutrition not responding to standard treatment □ Recurrent severe presumed bacterial infections such as: empyema pyomyositis, bone or joint infection, meningitis, sepsis but excluding pneumonia □ Pneumocystis carinii (jeroveci) pneumonia □ Chronic Herpes simplex virus infection ((orolabial or cutaneious for > 1 month) persistent or non-responsive to treatment) □ Extrapulmonary cryptococcosis including meningitis □ CMV retinitis or affecting another organ, with onset at age older than one month □ Oesophageal candidiasis □ Extrapulmonary TB (Excludes Lymph node tuberculosis) □ Chronic isosporiasis □ HIV Encephalopathy □ Symptomatic HIV associated Cardiomyopathy or HIV associated Nephropathy □ Kaposi's sarcoma □ Cerebral or B-cell non-Hodgkin lymphoma □ Cryptosporidiosis infection □ Coccidiomycosis infections □ Histoplasmosis infections □ Congenital toxoplasmosis (outside neonatal period) □ Non tuberculosis mycobacterial infection including disseminated BCG □ Progressive multifocal leukoencephalopathy

37. HIV-Related Diagnosis

Diagnosis	New	Ongoing	Resolved	Diagnosis	New	Ongoing	Resolved
1.	□	□	□	4.	□	□	□
2.	□	□	□	5.	□	□	□
3.				6.	□	□	□

38. Non-HIV Related Diagnosis ****For Other Diagnoses, tick box only if diagnosis needs to be Added to ,Ongoing or Removed from summary sheet****

Diagnosis	New	Ongoing	Resolved	Diagnosis	New	Ongoing	Resolved
1.	□	□	□	4.	□	□	□
2.	□	□	□	5.	□	□	□
3.	□	□	□	6.	□	□	□

39. Plan:

39a. ARVs:	□ None □ Start ARVs □ Continue Regimen □ Change Formulation □ Change Regimen □ Re-dose □ Drug substitution □ Re-start □ Stop All
39b. Reason for stop/change/re-dose:	□ Clinical treatment failure □Immunologic failure □ Virologic failure □ Weight Change □Completed pMTCT □ Drug out of stock □ Dose escalation of Nevirapine □ Toxicity ***(Specify)*:** _____ □ Due to new TB □ New drug Available □ Other : _____
39c. Eligible for ARVs but not started :	□ OI/TB TX □ Patient Refused □ Adherence Concerns □ Psychosocial ineligibility □Other:_____

39d. Treatment categories : □ First line □ Second line ***(following viral failure)*** □ Third line ***(Salvage regimen)***
If start or change or re-dose, tick all new regimens:

39e. ARV Drugs :			
□ Abacavir/Lamivudine **(ABC60 / 3TC30)**	□ Stavudine/Lamivudine/Nevirapine **(d4T12 / 3TC60 / NVP100)T-jr**	□ Lopinavir / Ritonavir _____**ml**	□ Didanosine(DDI) __**mg**
□ Zidovudine/Lamivudine**(ZDV60/3TC30)**	□ Stavudine/Lamivudine/Nevirapine **(d4T30 / 3TC150 / NVP200) > 25kgs**	□ Lopinavir / Ritonavir **(LPV200/ RIT50) >25kgs** _____**tabs**	□ Raltegravir ___**mg**
□ Zidovudine/lamivudine/Nevirapine **(ZDV60 / 3TC30 / NVP50)**	□ Zidovudine/Lamivudine **(ZDV300/3TC150) >25kgs**	□ Zidovudine (ZDV or AZT) _**mg / __ml**	□ Darunavir
□ Zidovudine/lamivudine/Nevirapine **(ZDV300 / 3TC150 / NVP200) > 25kgs**	□ Stavudine/Lamivudine **(D4T30/ 3TC150)>25kgs**	□ Ritonavir(**Rit100**)_____tabs	□ Atazanavir
□ Nevirapine(NVP) ____ **mg / ____ml**	□ Tenofovir / Lamivudine **(TDF300 / 3TC300) > 25kgs**	□ Ritonavir _____**mg** **(Norvir sec100)**	□ Unknown name
□ Efavirenz (EFV) ____ **mg / ____ml**	□ Tenofovir/Lamivudine/ Efavirenz **(TDF200/ 3TC600/ EFV300) > 25kgs**	□ Ritonavir____mg____**ml** **(Norvir80)**	□ Other :
□ Lamivudine (3TC)____ **mg / __ml**		□ Atazanavir/Ritonavir **(Atazanavir300/ritonavir100)**	
□ Abacavir (ABC) _____**mg / ____ml**			

39f. Opportunistic Infection prophylaxis:	□ None □ Start □ Continue Regimen □ Re-start □ Change Regimen □ Re-dose □Stop
39g. Reason for stop/change/re-dose:	□ Weight Change □ Toxicity (Specify) _____□ Other_____
39h. Drugs:	□ Septrin tabs _____ml □ Dapsone mg/day □ Diflucan
39i. TB Prophylaxis:	□ None □ Start INH □ Continue INH □ Re-dose □ Re-start □ Stop INH
39j. Reason for stop/change/re-dose:	□ Completed □ Active TB □ Weight Change □ Toxicity: _____□Other_____
39k. Drug Dose:	□ INH _____mg/day
39l.TB Treatment:	□ None □ Intensive/initiation □ Change to Continuation □ Continue Regimen □ Re-dose □ Drug substitution □ Stop □ Continue picking meds at other site Location: _____
39m. Reason for start :	□ New treatment 1st line □ Defaulted***(restart 1st line)*** □ Regimen failure***(start Retreatment)*** □ Relapse/re-infection ***(Retreatment)*** □ MDR TB regimen
39n. Reason for stop/change/re-dose:	□ Completed □ Weight Change □ Toxicity ***(Specify):*** □ Other:

30o.TB Meds:			
□ Rifafour(RHZE) ____tabs/day	□ Rifinah(RH) ____tabs/day	□ INH_____mg	□ MDR TB Drugs ***(Cycloserine,Protionamide,Capreomycin,Kanamycin, P.A.S, Levofloxasin,Pyridoxine)***
□ Rifater(RHZ)____tabs/day	□ Ethizide(EH) _____mg	□ Pyrazinamide _____mg	□ Other:
□ Ethambutol _____mg/day	□ Rifampicin_____mg	□ Rifabutin_____mg	
□ Streptomycin_____mg	□ 3-FDC(RHE)____tabs/day		

39p. Contact investigations Initiated***(invitation of household contacts of smear +ve)*** □ Yes □ No

40. Immunizations Ordered Today □ None □ Completed Schedule

□ BCG	□ Polio 0			
□ Penta 1	□ Polio 1	□ PCV 1	□ Rotavirus 1	□ Vitamin A ***(children under five only)***
□ Penta 2	□ Polio 2	□ PCV 2	□ Rotavirus 2 ***(given before 6 months)***	
□ Penta 3	□ Polio 3	□ PCV 3	□ Measles 0 ***(6months)*** □ Measles ***(9months)***	

41a. Feeding plan: □ Breastfeeding □ Expressed Breast milk □ Cow's/Animal milk □ Formula □ Other Liquids***(uji, tea, soup, juice)*** □ Solid food ***(ugali, potatoes, bananas)*** □ Initiate complementary feeding □ On family diet ***(for older children)***

41b. If this is a change, reason: □ Age □ Affordability □ Reaction □ Other***(Specify):***

42.Disclosure Plan: □ Not initiated ***(child with good cognition normally > 7-10yrs)*** □ Initiated □ Continued □ Completed □ N/A ***(child with poor cognition normally < 7-10yrs)***

43. Additional Drugs Started or Re-dosed at this Visit:

Drug	Dose	Freq & Duration	New	DoseΔ
1.			□	□
2.			□	□
3.			□	□

44. Tests Ordered:

□ None	□ Full Haemogram	□ Hgb	□ SGPT	□ CD4 Panel	**Sputum :** □ AFB Smear □ Culture
□ HIV DNA PCR	□ CXR	□ Viral Load	□ Creatinine	□ HIV Elisa	□ Gene Xpert □TST ***(Mantoux test)***

□ Other ***(Specify):***

45. Referrals:

□ None	□ TB treatment/DOT program	□ Nutritional support	□ Disclosure Counseling	□ Ophthalmology
□ OVC	□ Adherence Counseling	□ Social Support Services	□ Express care	□ Oncology
□ ENT	□ Mental Health Services	□ Psychosocial counseling	□ Reproductive Health	□ Cardiology
□ Surgery	□ Dermatology	□ Other referral ***(specify):***_____		

□ Inpatient care/Hospitalization (□ MTRH □ Health Center) □ Other

Patient Plan Comments:

46. When is the patient's next appointment Weeks _____ Months _____ **Appointment Date** __ ___ / __ ___ / _____
d d m m y y y y

Nurse:	**P#:**	**Medical Officer:**	**P#:**
Clinical Officer:	**P#:**	**Consultant Pediatrician:**	**P#:**