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PAEDIATRIC RETURN ENCOUNTER FORM v5.02

Date / /

First name *Last name* *Middle name*

Indicate patients phone number if it changed since last visit :

AMRS I.D: ☐☐☐☐☐☐☐☐☐ — ☐ **AMPATH I.D:** **Unique patient ID*(GOK)*:**

TB registration ID: **DOB:** / / **Age*(yrs)*:** **Mos:** Patient covered by NHIF ☐Yes ☐No

Mother's Name: **AMPATH/AMRS ID:** ☐☐☐☐☐☐☐☐☐ — ☐

Father's Name: **AMPATH/AMRS ID:** ☐☐☐☐☐☐☐☐☐ — ☐

Has the patient changed their residence? ☐ Yes ☐ No If Yes, indicate **County** : **Location:**

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. Transfer in care from other center: ☐ AMPATH***(specify):***

4a. ☐ Scheduled Visit ☐ Unscheduled Visit Early ☐ Unscheduled Visit Late **4b.**If unscheduled, actual scheduled date ___/___/_____

5a. Mother deceased: ☐ Yes ☐ No ☐ Unknown **5b.** Father deceased: ☐ Yes ☐ No ☐ Unknown

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

7a. Current Feeding*: **tick all that apply*** ☐ Breastfeeding ☐ Formula ☐ Water ☐ Solid Food ☐ Cow's/Animal milk ☐ Expressed breast milk ☐ Other liquids ☐ Completely Weaned ☐ On family diet ***(for older kids)***

7b. If breastfeeding, is mother on ARVs ☐ Yes ☐ No ☐ Unknown **8a.** Are there Siblings < 18 months ☐ Yes ☐ No ☐ N/A

8b. If yes for ***siblings < 18 months*** are they registered in Pediatric HIV clinic ☐ Yes ☐ No ☐ Unknown

8c. If yes AMPATH/ AMRS ID's:

9a. Previous Immunizations**:** ☐ None ☐ Completed schedule

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

9b. Immunizations confirmed from card: ☐ Yes ☐ No

10. Child's Current HIV Status**:** ☐ HIV exposed, status indeterminate ☐ HIV infected ☐ HIV Negative

11. 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)***

12a. Has patient been hospitalized since last visit ☐ Yes ☐ No

12b. Reason: 1._____ 2._____ 3._____

13.Current Medications:

13a. ARVs use: ☐ Yes ☐ No **13b.** (***If Yes then)*** Reason for ARV's: ☐ pMTCT ☐ Clinical disease

13c. If started since last visit record the date _____/_____/_____

13d. Treatment categories: ☐ First line ☐ Second line***(following viral failure)*** ☐ Third line***(Salvage regimen)***

13e. Current 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 _____tab (LPV200/ RIT50) > 25kgs	☐ 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 (TDF300/ 3TC300/ EFV600) > 25kgs	☐ Ritonavir_____mg_____ml (Norvir80)	☐ Other :
☐ Lamivudine (3TC)____ mg / __ml		☐ Atazanavir/Ritonavir (Atazanavir300/ritonavir100)	
☐ Abacavir (ABC)_____mg / ____ml			

13f. Opportunistic Infection***(OI)*** Prophylaxis : ☐ None ☐ Cotrimoxazole ***(Septrin)*** ☐ Dapsone ☐ Fluconazole ___mg***(Diflucan)***

13g. TB Prophylaxis: ☐ None ☐ INH 100mg ☐ INH 300mg **13h.** If on TB prophylaxis, start date _____/_____/_____

13i. TB Treatment: ☐ None ☐ On Treatment (**Start Date of TB treatment:** _/___/_____)

13j. Site of TB meds pick-up: ☐ None ☐ This AMPATH site ☐ Other ***(specify):*** _____

13k. TB Meds : □ Rifafour(RHZE) ____tabs/day □ Rifater(RHZ)____tabs/day □ Ethambutol _____mg/day □ Streptomycin_____mg	□ Rifinah(RH) ____tabs/day □ Ethizide(EH) _____mg □ Rifampicin_____mg □ 3-FDC(RHE)____tabs/day	□ INH_____mg □ Pyrazinamide _____mg □ Rifabutin_____mg	□ MDR TB Drugs ***(Cycloserine,Protionamide,Capreomycin,Kanamycin, P.A.S, Levofloxasin,Pyridoxine)*** □ Other: □ Completed (Date:____/____/_____)

13l. Other current drugs ***(specify):***

14. Adherence:

14a. Who has been giving the medicine to the patient ***(Please tick all that apply):*** □ Mother □ Father □ Sibling □ Grandparent □ Auntie □ Uncle □ Self □ Children's Home □ Other ***(Specify):***

14b. During the last month has the patient missed any medications □ Yes □ No

14c. Drugs missed : □ ARVS □ PCP Prophylaxis □ TB Prophylaxis □ Anti-TB Rx

14d. Reason***(s)*** Tick all that apply:	□ Traveled □ Too ill □ Pill burden	□ Depression □ Forgetting □ Felt better □ Other	□ Side effects □ Ran out of drugs □ Away from home □ Share with others	□ Care giver unable to give □ Child refused/Not wanting to be seen □ Did not pick drugs/Couldn't get □ Problem traveling to clinic □ Other treatment ***(herbal medicine/other medicine)***

14e. During the last seven days how many of his/her pills did the patient take

□ ARVS:	□ None	□ Few	□ Half	□ Most	□ All	Drug***(s)*** missed:
□ OI Prophylaxis :	□ None	□ Few	□ Half	□ Most	□ All	Drug***(s)*** missed:
□TB Prophylaxis :	□ None	□ Few	□ Half	□ Most	□ All	Drug***(s)*** missed:
□TB Treatment :	□ None	□ Few	□ Half	□ Most	□ All	Drug***(s)*** missed:

14f. Side-effects/Toxicity: Any side effects attributable to any drug that the child is ***currently taking*** □ Yes □ No

14g. *If Yes, drug(s)* :_____

14h. *If yes, tick all that apply:*	□ Rash □ Lactic Acidosis	□ Anemia □ Diarrhea	□ Lipo-dystrophy □ Steven-Johnson syndrome	□ Hepatitis	□ Neuropathy □ IRIS □ Persistent Vomiting
	□Other (specify):				
14i. Severity of the reaction:	□ Mild	□ Moderate	□ Severe	□ Unknown	□ Other ***(specify):***
14j. Cause of the reaction/toxicity:	□ Certain	□ Probable/Likely	□ Possible	□ Unlikely	□ Conditional/Unclassified
	□ Unassessable/Unclassified				

15. Does the patient have any interval complaints □ Yes □ No If Yes, tick all that apply

□ Diarrhea:	□ Days	□ Weeks	□ Abdominal pain:	□ Days	□ Weeks	□ Skin rash:	□ Days	□ Weeks
□ Sore throat:	□ Days	□ Weeks	□ Difficulty breathing:	□ Days	□ Weeks	□ Vomiting:	□ Days	□ Weeks
□ Cough:	□ Days	□ Weeks	□ Fever:	□ Days	□ Weeks	□ Ear discharge:	□ Days	□ Weeks
□ Sores:	□ Days	□ Weeks	□ Swelling ***(specify):***				□ Days	□ Weeks
Comments :			□ Other ***(specify)*:**				□ Days	□ Weeks

16. Physical Exam:

16a. Does the child have growth faltering ***(FTT)*** □ Yes □ No ***(If Yes, refer to nutritionist)*** **16b.Is the child overweight** □ Yes □ No***(If Yes, refer to nutritionist)***

16c. Does Child have a disability : □ Yes □ No

16d.*If Yes:* □ Cerebral Palsy □ Physical disability: □ Mental Disability: □ Other Specify :

16e.General: □ Jaundice □ Pale □ Adenopathy □ Edema □ Thrush □ Kaposi □ Rash □ Parotid enlargement

RS: □ Normal □ Abnormal **PA:** □ Normal □ Abnormal **CVS:** □ Normal □ Abnormal **MS:** □ Normal □ Abnormal **CNS:**□ Normal □Abnormal

HEENT : □ Normal □ Abnormal **Examination notes:**

17.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=PI 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		
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		

18a.WHO Stage: □ 1 □ 2 □ 3 □ 4 Criteria _____ New Stage □ Yes □ No

18b. Not Applicable:□ Discontinued from HIV follow up, HIV negative ***(child to be seen 6 monthly till 5 yrs)***□ HIV Exposed, status indeterminate

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 lymphnodes)***
(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 necessary. 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

20. Diagnosis: (** Tick "Add" to add to summary sheet. Tick "Remove" to delete to from summary sheet*)

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

21.Plan:

21a. ARVs:	□ None □ Start ARVs □ Continue Regimen □ Change Formulation □ Change Regimen □ Re-dose □ Drug substitution □ Re-start □ Stop All
21b. 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 : _____
21c. Eligible for ARVs but not started :	□ OI/TB TX □ Patient Refused □ Adherence Concerns □ Psychosocial ineligibility □Other:

21d. Treatment categories □ First line □ Second line ***(following viral failure)*** □ Third line***(Salvage regimen)***

21e. 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 _____**tab** **(LPV200/ RIT50) > 25kgs**	□ 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 **(TDF300/ 3TC300/ EFV600) > 25kgs**	□ Ritonavir____**mg**____**ml** **(Norvir80)**	□ Other :
□ Lamivudine (3TC)____ **mg / ml**		□ Atazanavir/Ritonavir **(Atazanavir300/ritonavir100)**	
□ Abacavir (ABC)_____**mg /** ____**ml**			

21f. Opportunistic Infection prophylaxis:	□ None □ Start □ Continue Regimen □ Restart □ Change Regimen □ Re-dose □Stop
21g. Reason for stop/change/re-dose:	□ Weight Change □ Toxicity ***(Specify):*** _____□ Other_____
21h. Drugs:	□ Septrin _____ml □ Dapsone mg/day □ Diflucan
21i. TB Prophylaxis:	□ None □ Start INH □ Continue INH □ Re-dose □ Re-start □ Stop INH
21j. Reason for stop/change/re-dose:	□ Completed □ Active TB □ Weight Change □ Toxicity: _____□Other_____
21k. Drug Dose:	□ INH _____mg/day
21l.TB Treatment:	□ None □ Intensive/initiation □ Change to Continuation □ Continue Regimen □ Re-dose □ Drug substitution □ Stop □ Continue picking meds at other site Location: _____
21m. Reason for start :	□ New treatment 1st line □ Defaulted***(restart 1st line)*** □ Regimen failure***(start Retreatment)*** □ Relapse/re-infection ***(Retreatment)*** □ MDR TB regimen
21n. Reason for stop/change/re-dose:	□ Completed □ Weight Change □ Toxicity ***(Specify):*** □ Other:

21o.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		

21p. Contact investigations Initiated**(*invitation of household contacts of smear +ve)*** □ Yes □ No

21q. Immunizations Ordered Today □ None □ Completed schedule

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

21r. Feeding plan: □ Breastfeeding □ Expressed Breast milk □ Formula □ Cow's/Animal milk □ Other Liquids **(uji, tea, soup, juice)**
□ Solid food (ugali, potatoes, bananas) □ Initiate complementary feeding □ On family diet (for older children)

21s. If this is a change, reason: □ Age □ Affordability □ Reaction □ Other(Specify):

22.Disclosure Plan

22a. This child □ Not initiated ***(child with good cognition normally > 7-10yrs)*** □ Initiated □ Continued □ Completed
□ N/A ***(child with poor cognition normally less than 7-10yrs)***

23. Additional Drugs at this Visit	**Freq&Dura**	**New**	**Dose∆**	**Additional Drugs at this Visit**	**Freq&Dura**	**New**	**Dose∆**
1.		□	□	**4.**		□	□
2.		□	□	**5.**		□	□

24. Tests Ordered:

□ None □ Full Haemogram □ Hgb □ SGPT □ CD4 Panel □ Viral load □ HIV Elisa □ HIV DNA PCR □ Creatinine
□ CXR □ Other specify :

25. Referrals Ordered :

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

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

Additional Comments:

26. □ Discontinued from HIV follow up, HIV negative ***(child to be seen 6 monthly till 5 yrs using pediatric under five follow-up form)***
27. □ Transfer care to other centre:
□ **AMPATH** _____ _____ □ **NON-AMPATH TO:** _____
28. Return to Clinic: Weeks **Months** **Date**___/___/___

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