

**AMPATH: Adult Return Visit Short Form**

Date: \_\_\_\_\_

<b>1. Name:</b>	<b>AMPATH ID:</b>	<b>Previous ID:</b>
<b>2. Location:</b> MTRH Module: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Health Centre: <input type="checkbox"/> Mosoriot <input type="checkbox"/> Turbo <input type="checkbox"/> Burnt Forest <input type="checkbox"/> Amukura <input type="checkbox"/> Naitiri <input type="checkbox"/> Chulaimbo <input type="checkbox"/> Webuye <input type="checkbox"/> Kitale <input type="checkbox"/> Kapenguria <input type="checkbox"/> Teso	<b>3. Category:</b> <input type="checkbox"/> Pilot <input type="checkbox"/> MTRH Staff <input type="checkbox"/> MTCT Staff <input type="checkbox"/> NASCOP <input type="checkbox"/> Research <input type="checkbox"/> Self Pay <input type="checkbox"/> Other	<b>4. Member of Discordant Couple?:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>5. Female Patients:</b>		
<b>5a.</b> Is the patient pregnant? <input type="checkbox"/> Yes _____Weeks <input type="checkbox"/> No (Go to 5b)	<b>If yes:</b> On ARV-directed pMTCT <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5b.</b> Has she delivered since her last visit? <input type="checkbox"/> Yes Date_____ <input type="checkbox"/> No (Go to 6) How was the mother treated? <input type="checkbox"/> Total pMTCT <input type="checkbox"/> NVP <input type="checkbox"/> Untreated <input type="checkbox"/> On ARV Therapy <input type="checkbox"/> Unknown Infant received NVP? <input type="checkbox"/> Yes <input type="checkbox"/> No Feeding Method? <input type="checkbox"/> Breast <input type="checkbox"/> Predominate Breast <input type="checkbox"/> Formula <input type="checkbox"/> Mixed feeding <input type="checkbox"/> Weaned Baby enrolled in Peds HIV Clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>6. Does the patient have any interval complaints?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Comments:		
<b>7. Current Medications:</b>		
<b>ARVs:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Is this the patient's Primary Regimen? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Combivir <input type="checkbox"/> Triomune-30 <input type="checkbox"/> Triomune-40 <input type="checkbox"/> 3TC <input type="checkbox"/> d4T-30 <input type="checkbox"/> d4T-40 <input type="checkbox"/> AZT <input type="checkbox"/> ABC <input type="checkbox"/> DDI 125 <input type="checkbox"/> DDI 200 <input type="checkbox"/> TDF <input type="checkbox"/> EFV <input type="checkbox"/> NVP <input type="checkbox"/> NFV <input type="checkbox"/> Kaletra (Lopinavir/Ritonavir)		
<b>PCP Prophylaxis:</b> <input type="checkbox"/> None <input type="checkbox"/> Septrin <input type="checkbox"/> Dapsone		
<b>TB Prophylaxis:</b> <input type="checkbox"/> None <input type="checkbox"/> INH		
<b>TB Treatment:</b> <input type="checkbox"/> None <input type="checkbox"/> Rifater (Rifampicin/Pyrazinamide/INH) <input type="checkbox"/> Ethizide (Ethambutol/INH) <input type="checkbox"/> Ethambutol <input type="checkbox"/> Streptomycin Start Date of TB treatment:_____		
<b>Cryptococcus Tx:</b> <input type="checkbox"/> None <input type="checkbox"/> Diflucan		
<b>Other Drugs:</b>		
<b>8. Adherence:</b>		
<b>During the last month has the patient missed any medications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> ARVS <input type="checkbox"/> PCP Prophylaxis <input type="checkbox"/> TB Prophylaxis <input type="checkbox"/> Anti-TB Medication Drugs Missed: _____ Reason(s): _____		
<b>During the last seven days how many of his/her pills did the patient take?</b> <input type="checkbox"/> ARVS: <input type="checkbox"/> None <input type="checkbox"/> Few <input type="checkbox"/> Half <input type="checkbox"/> Most <input type="checkbox"/> All Drug(s) missed _____ <input type="checkbox"/> PCP Prophylaxis: <input type="checkbox"/> None <input type="checkbox"/> Few <input type="checkbox"/> Half <input type="checkbox"/> Most <input type="checkbox"/> All Drug(s) missed _____ <input type="checkbox"/> TB Prophylaxis: <input type="checkbox"/> None <input type="checkbox"/> Few <input type="checkbox"/> Half <input type="checkbox"/> Most <input type="checkbox"/> All Drug(s) missed _____ <input type="checkbox"/> Anti-TB Medication: <input type="checkbox"/> None <input type="checkbox"/> Few <input type="checkbox"/> Half <input type="checkbox"/> Most <input type="checkbox"/> All Drug(s) missed _____ Reason(s) for missing pills in the last 7 days: _____		
<b>9. Physical Exam:</b>		
BP _____ / _____ P _____ Temp _____ Wt _____ Height _____ SaO <sub>2</sub> _____ <b>General:</b> <input type="checkbox"/> Jaundice <input type="checkbox"/> Pale <input type="checkbox"/> Adenopathy <b>Mucocutaneous:</b> <input type="checkbox"/> Thrush <input type="checkbox"/> Kaposi <input type="checkbox"/> Rash Comments:		
<b>10. Current WHO Stage:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Criteria: _____ New Stage? <input type="checkbox"/> Yes <input type="checkbox"/> No		

11. Test Results: (Please record date test was drawn, rather than date test was run)							
Test	Result	Test Date	Test	Result	Test Date		
WBC/mm <sup>3</sup>			CD4				
Hgb g/dL			CD8				
MCV			CD4%				
Platelets/ mm <sup>3</sup>			VDRL				
ALC/ mm <sup>3</sup>			Other				
SGPT							
Creat mmol/L							
CXR	Code			Codes: 0=normal 1=PI Effusion 2=Infiltrate	3=Miliary 4=Diffuse abn/non-miliary 5=Cavity	6=Cardiomegaly 7=Other abnormality	
<b>12. Impression:</b> New Problems							
* Tick "Add" to add a problem to summary sheet. Tick "Remove" to delete problem from summary sheet							
Problem	Code	Add	Remove	Problem	Code	Add	Remove
1.		<input type="checkbox"/>	<input type="checkbox"/>	3.		<input type="checkbox"/>	<input type="checkbox"/>
2.		<input type="checkbox"/>	<input type="checkbox"/>	4.		<input type="checkbox"/>	<input type="checkbox"/>
<b>13. Plan:</b>							
<b>ARVs:</b> <input type="checkbox"/> None <input type="checkbox"/> Start ARVs <input type="checkbox"/> Continue Regimen <input type="checkbox"/> Change Formulation <input type="checkbox"/> Change Regimen <input type="checkbox"/> Stop All Reason to start ARVs: <input type="checkbox"/> Treatment <input type="checkbox"/> Total pMTCT Reason for stop/change: <input type="checkbox"/> Failure <input type="checkbox"/> Toxicity <input type="checkbox"/> Completed T-pMTCT <input type="checkbox"/> Other _____ <b>If start or change, tic new regimen:</b> Combination: <input type="checkbox"/> Combivir <input type="checkbox"/> Triomune-30 <input type="checkbox"/> Triomune-40 Individual: <input type="checkbox"/> 3TC <input type="checkbox"/> d4T-30 <input type="checkbox"/> d4T-40 <input type="checkbox"/> AZT <input type="checkbox"/> ABC <input type="checkbox"/> DDI-125 <input type="checkbox"/> DDI-200 <input type="checkbox"/> TDF <input type="checkbox"/> EFV <input type="checkbox"/> NVP <input type="checkbox"/> NFV <input type="checkbox"/> Kaletra (Lopinavir/Ritonavir)							
<b>PCP Prophylaxis:</b> <input type="checkbox"/> None <input type="checkbox"/> Start <input type="checkbox"/> Continue Regimen <input type="checkbox"/> Change Regimen <input type="checkbox"/> Stop Reason for stop/change: <input type="checkbox"/> CD4>200 <input type="checkbox"/> Toxicity <input type="checkbox"/> Other _____ New Drugs: <input type="checkbox"/> Septrin <input type="checkbox"/> Dapsone							
<b>TB Prophylaxis:</b> <input type="checkbox"/> None <input type="checkbox"/> Start INH <input type="checkbox"/> Continue INH <input type="checkbox"/> Stop INH Reason for stop/change: <input type="checkbox"/> Completed <input type="checkbox"/> Toxicity <input type="checkbox"/> Active TB <input type="checkbox"/> Other _____							
<b>TB Treatment:</b> <input type="checkbox"/> None <input type="checkbox"/> Start Induction <input type="checkbox"/> Change to Continuation <input type="checkbox"/> Continue Regimen <input type="checkbox"/> Stop Reason for stop/change: <input type="checkbox"/> Completed Induction or Treatment <input type="checkbox"/> Toxicity <input type="checkbox"/> Other _____ New Drugs: <input type="checkbox"/> Rifater (Rifampicin/Pyrazinamide/INH) _____ tabs/day <input type="checkbox"/> Ethizide (Ethambutol/INH) _____ tabs/day <input type="checkbox"/> Ethambutol _____ tabs/day <input type="checkbox"/> Streptomycin _____ mg/day							
<b>Cryptococcus Tx:</b> <input type="checkbox"/> None <input type="checkbox"/> Start Diflucan <input type="checkbox"/> Continue Diflucan <input type="checkbox"/> Stop Diflucan							
<b>Additional Drugs Started This Visit:</b>							
Drug	Dose	Freq & Duration	Drug	Dose	Freq & Duration		
1.			3.				
2.			4.				
<b>Tests Ordered:</b>							
<input type="checkbox"/> Full Haemogram <input type="checkbox"/> Hgb <input type="checkbox"/> SGPT <input type="checkbox"/> CD4 Panel <input type="checkbox"/> Viral Load <input type="checkbox"/> HIV Elisa <input type="checkbox"/> HIV DNA PCR <input type="checkbox"/> Creatinine <input type="checkbox"/> CXR <input type="checkbox"/> Other (Specify): _____							
Referrals Given: _____							
Additional Comments: _____							
Return to Clinic: Weeks _____ Months _____ Date _____ CO/Physician: _____							
Hospitalization: <input type="checkbox"/> MTRH <input type="checkbox"/> Health Center <input type="checkbox"/> Other _____ Provider #: _____							
<b>For Community Clinics:</b> Medication picked-up at this visit: <input type="checkbox"/> Yes <input type="checkbox"/> No							