

AMPATH ADULT INITIAL ENCOUNTER FORM		Date:
Name:		AMPATH ID:
Date of Birth:		MTRH ID:
Tribe:	Age at last Birthday:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Location:	Location:	Sublocation:
Location: 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 <input type="checkbox"/> Other:		Category: <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"/> Awaiting Assignment <input type="checkbox"/> Other:
Social History:		
1. How long did it take you to travel to clinic today? <input type="checkbox"/> Less than 30 minutes <input type="checkbox"/> Between 30 and 60 minutes <input type="checkbox"/> Between 1 and 2 hours <input type="checkbox"/> More than 2 hours	10. Are you currently married or living with a partner? <input type="checkbox"/> Yes <input type="checkbox"/> No (Check all that apply) <input type="checkbox"/> No- Never married <input type="checkbox"/> No- Divorced <input type="checkbox"/> No- Spouse died <input type="checkbox"/> Separated <input type="checkbox"/> Yes - legally married: Number of wives _____ <input type="checkbox"/> Yes - living with partner (not married)	
2. Have you ever attended school? <input type="checkbox"/> Yes <input type="checkbox"/> No 2a. If yes, how many years of school have you completed? _____ Years	10a. How do you think you were exposed to HIV? (Check all that apply) <input type="checkbox"/> Spouse, sexual partner, or co-wife suspected to have HIV or died of HIV <input type="checkbox"/> Suspicion of HIV as cause of death of spouse/partner Year of death _____ <input type="checkbox"/> Patient knows spouse or partner is HIV+ <input type="checkbox"/> Suspected past exposure (prior to relationship) <input type="checkbox"/> Blood Transfusion _____ Date of Transfusion (Year) <input type="checkbox"/> No known risk <input type="checkbox"/> Other _____	
3. Are you employed outside the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	10b. Discordant couple? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
4. Do you have electricity inside your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	10c. Sexual Activity: <input type="checkbox"/> Yes <input type="checkbox"/> No - Spouse or partner suspected of sex partner outside of marriage/relationship <input type="checkbox"/> Yes <input type="checkbox"/> No - Patient has sex partners outside marriage or current relationship <input type="checkbox"/> Yes <input type="checkbox"/> No - Sexually active last 6 months Number of different partners: _____	
5. Do you have water piped (from a tap) inside your home? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No [If yes, skip to 12]	
6. How many people usually live in your household or are staying with you now? _____ 6a. Children under 5 years of age? _____	11a. Is the patient or their partner currently using any form of family planning? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, fill on box for all that apply</i> <input type="checkbox"/> Yes <input type="checkbox"/> No - Condoms <input type="checkbox"/> Yes <input type="checkbox"/> No - Oral Contraceptive Pills <input type="checkbox"/> Yes <input type="checkbox"/> No - Intrauterine Device <input type="checkbox"/> Yes <input type="checkbox"/> No - Sterilization / Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No - Natural Family Planning / Rhythm <input type="checkbox"/> Yes <input type="checkbox"/> No - Diaphragm / Cervical Cap <input type="checkbox"/> Yes <input type="checkbox"/> No - Injectable Hormones (e.g., Depo-provera) or Implants (e.g., Norplant) <input type="checkbox"/> Other _____	
7. Have you disclosed your HIV status to anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No 7a. If yes, have you told any of the following people? <input type="checkbox"/> Partner/spouse <input type="checkbox"/> Other family member <input type="checkbox"/> Friend <input type="checkbox"/> Other household member <input type="checkbox"/> Health care provider <input type="checkbox"/> Other (specify): _____	8. How many times have you been pregnant? _____ 9. To how many children have you given birth? _____ 9a. Number of <u>your</u> children living with you now: _____ 9b. Number of <u>your</u> children living with you now <5 yrs old: _____	
Women Only:	Men Only:	
8c. How many children do you have? _____		

23. Other Current Medications:		
PCP Prophylaxis: <input type="checkbox"/> None <input type="checkbox"/> Septrin <input type="checkbox"/> Dapsone		
TB Prophylaxis: <input type="checkbox"/> None <input type="checkbox"/> INH		
TB Treatment: <input type="checkbox"/> None <input type="checkbox"/> Rifater <input type="checkbox"/> Rifafour <input type="checkbox"/> Ethizide (Ethambutol/INH) <input type="checkbox"/> Rifampicin <input type="checkbox"/> INH <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Ethambutol <input type="checkbox"/> Streptomycin Start Date _____		
Cryptococcus Tx: <input type="checkbox"/> None <input type="checkbox"/> Diflucan		
Other Drugs:		
24. Alcohol Use Questions (AUDIT-3)		
<p>How often did you have a drink containing alcohol in the last year?</p> <input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2 to 4 times a month <input type="checkbox"/> 2 to 3 times a week <input type="checkbox"/> 4 to 5 times a week <input type="checkbox"/> 6 or more times a week	<p>How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?</p> <input type="checkbox"/> 0 drinks <input type="checkbox"/> 1 to 2 drinks <input type="checkbox"/> 3 to 4 drinks <input type="checkbox"/> 5 to 6 drinks <input type="checkbox"/> 7 to 9 drinks <input type="checkbox"/> 10 or more drinks	<p>How often did you have six or more drinks on one occasion in the past year?</p> <input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily
PHYSICAL EXAMINATION		
25. Vitals: BP _____ / _____ P _____ rate/min Temp[Co] _____ SaO2 _____ % Wt _____ kg Height _____ cm Karnofsky Score _____ %		
26. General Exam: <input type="checkbox"/> Temporal wasting Comments:		
28. Skin <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Rash <input type="checkbox"/> Kaposi sarcoma Comments:		
29. Lymph Nodes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> submandibular <input type="checkbox"/> cervical <input type="checkbox"/> inguinal <input type="checkbox"/> supraclavicular <input type="checkbox"/> axillary Comments:		
30. HEENT <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Eyes: <input type="checkbox"/> Sclera icteric <input type="checkbox"/> Conjunctiva pale <input type="checkbox"/> Fundal abnormality Ears: <input type="checkbox"/> Cerumen impaction <input type="checkbox"/> TM injected Neck: <input type="checkbox"/> Trachea deviated <input type="checkbox"/> Nuchal rigidity Oropharynx: <input type="checkbox"/> Thrush <input type="checkbox"/> Kaposi sarcoma <input type="checkbox"/> Significant dental caries Comments:		
31. Chest <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Percussion <input type="checkbox"/> Dullness <input type="checkbox"/> Left base <input type="checkbox"/> Right base Auscultation <input type="checkbox"/> Breath sounds diminished <input type="checkbox"/> Bronchial breath sounds Location _____ <input type="checkbox"/> Wheezes <input type="checkbox"/> Rhonchi <input type="checkbox"/> Crepitations Location _____ Comments:		
32. Heart <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Evidence for enlargement <input type="checkbox"/> LV lift <input type="checkbox"/> RV lift <input type="checkbox"/> Abnormal Sounds <input type="checkbox"/> S3 Gallop <input type="checkbox"/> Pericardial friction rub <input type="checkbox"/> Murmurs <input type="checkbox"/> Systolic Ejection Murmur <input type="checkbox"/> Holosystolic Murmur <input type="checkbox"/> Diastolic Decrescendo <input type="checkbox"/> Diastolic Rumble Comments:		
33. Abdomen <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Tender to palpation Location _____ <input type="checkbox"/> Ascites <input type="checkbox"/> Mass <input type="checkbox"/> Hepatomegaly _____ (Cm below costal margin) <input type="checkbox"/> Splenomegaly _____ (Cm below costal margin) Comments:		
34. Urogenital <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not done Comments:		
35. Extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Edema <input type="checkbox"/> Leg ulcers <input type="checkbox"/> Cellulitis <input type="checkbox"/> Kaposi sarcoma Comments:		
36. Musculoskeletal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments:		
37. Neurologic <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Cranial nerve abnormality <input type="checkbox"/> Decreased sensation lower extremities <input type="checkbox"/> Abnormal gait <input type="checkbox"/> Focal weakness Comments:		
38. Psychiatric <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Depressed <input type="checkbox"/> Dementia / confused Comments:		

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

Fill in the appropriate box next to each indicator condition

WHO Stage 1		WHO Stage 4	
Asymptomatic HIV Infection	<input type="checkbox"/>	Candidiasis (Esophageal, Bronchi, Trachea, or Lungs)	<input type="checkbox"/>
Persistent Generalized Lymphadenopathy (PGL)	<input type="checkbox"/>	Cryptococcosis, Extrapulmonary	<input type="checkbox"/>
WHO Stage 2		Cryptosporidiosis with Diarrhea (> 1 month duration)	<input type="checkbox"/>
Herpes Zoster (within the last 5 years)	<input type="checkbox"/>	Cytomegalovirus Disease (other than liver, spleen, lymph nodes)	<input type="checkbox"/>
Minor Mucocutaneous Manifestations	<input type="checkbox"/>	Herpes Simplex (mucocutaneous>1 mo, or any visceral)	<input type="checkbox"/>
Recurrent Upper Respiratory Tract Infections	<input type="checkbox"/>	HIV Encephalopathy	<input type="checkbox"/>
Weight Loss ≤ 10% of Body Weight	<input type="checkbox"/>	HIV Wasting Syndrome	<input type="checkbox"/>
WHO Stage 3		Kaposi's Sarcoma (KS)	<input type="checkbox"/>
Severe Bacterial Infections (ie. pneumonia)	<input type="checkbox"/>	Lymphoma	<input type="checkbox"/>
Oral Candidiasis (Thrush)	<input type="checkbox"/>	Atypical Mycobacteriosis, Disseminated	<input type="checkbox"/>
Unexplained Chronic Diarrhea (>1 month)	<input type="checkbox"/>	Tuberculosis, Extrapulmonary	<input type="checkbox"/>
Oral Hairy Leukoplakia	<input type="checkbox"/>	Progressive Multifocal Leukoencephalopathy (PML)	<input type="checkbox"/>
Unexplained Prolonged Fever (intermittent or constant, >1 month)	<input type="checkbox"/>	Mycosis, Disseminated Endemic (ie. Histoplasmosis, Coccidiomycosis)	<input type="checkbox"/>
Tuberculosis, Pulmonary (within previous year)	<input type="checkbox"/>	Pneumocystic Carinii Pneumonia (PCP)	<input type="checkbox"/>
	<input type="checkbox"/>	Salmonella Septicemia, Non-typhoid	<input type="checkbox"/>

40. Tests

Test	Result	Test Date	Test	Result	Test Date
1. WBC / mm ³			8. CD4		
2. Hgb g / dL			9. CD8		
3. MCV			10. CD4 %		
4. Platelets / μL			11. VDRL		
5. ALC / mm ³			12. HIV Test (ELISA)		
6. SGPT μ/ L			13. Viral Load		
7. Creatinine mmol / L			14. Other		
15. CXR	Code:		Codes:	0=normal 1=PI Effusion 2=Infiltrate 3=Miliary	4=Diffuse abn/non-miliary 5=Cavity 6=Cardiomegaly 7=Other abnormality

42. HIV-related Problems

Problem	Code	Resolved	Problem	Code	Resolved
1.		<input type="checkbox"/>	4.		<input type="checkbox"/>
2.		<input type="checkbox"/>	5.		<input type="checkbox"/>
3.		<input type="checkbox"/>	6.		<input type="checkbox"/>

Non HIV-related Problems * For Other Problems, tick box only if problem needs to be added to or removed from summary sheet

Problem	Add	Remove	Problem	Add	Remove
1.	<input type="checkbox"/>	<input type="checkbox"/>	4.	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	5.	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	6.	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Plan:

ARVs: None Start ARVs Continue Regimen Change Formulation Change Regimen Stop All

Reason to start ARVs: Treatment Total pMTCT

Reason for stop/change: Failure Toxicity Completed T-pMTCT Other _____

If start or change, tick new regimen:

Combination: Combivir Triomune-30 Triomune-40

Individual: 3TC d4T-30 d4T-40 AZT ABC DDI-125 DDI-200 TDF
 EFV NVP NFV Kaletra (Lopinavir/Ritonavir)

PCP Prophylaxis: None Start Continue Regimen Change Regimen Stop

Reason for stop/change: CD4>200 Toxicity Other _____

New Drugs: Septrin _____ tabs/day Dapsone _____ mg/day

TB Prophylaxis: None Start INH Continue INH Stop INH

Reason for stop/change: Completed Toxicity Active TB Other _____

TB Treatment: None Start Induction Change to Continuation Continue Regimen Stop

Reason for stop/change: Completed Toxicity Other _____

New Drugs: Rifater _____ tabs/day Rifafour _____ tabs/day Ethizide _____ tabs/day Ethambutol _____ tabs/day
 Streptomycin _____ mg Rifampicin _____ mg INH _____ mg Pyrazinamide _____ mg

45. Additional Drugs (ordered at the time of the initial visit)

Drug	Strength	Sig	Drug	Strength	Sig
1.			4.		
2.			5.		
3.			6.		

46. Patient Plan Comments:

47. What tests will be ordered for the patient?

- None VDRL Tuberculin Skin Test
- Complete Blood Count ALT (Alanine Aminotransferase) Sputum for AFB
- CD4 Count Assay AST (Aspartate Aminotransferase) Pregnancy Test
- HIV ELISA Creatinine Radiology Test (specify):
- HIV Viral load Electrolytes Other (specify):

48. What referrals will be made for the patient?

- None Social Support Services Psychosocial counseling
- Family Planning services TB treatment/DOT program Disclosure counseling
- Nutritional support Adherence Counseling Other referral (specify):
- Inpatient care/Hospitalization Mental Health Services

49. When is the patient's next appointment? Fill in appropriate box:

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

50. Appointment Date ___ / ___ / ___
 d d m m y y y y

Form completed today by: Clinical Officer _____ Provider #: _____

Consultant _____ Provider #: _____