

**AMPATH Paediatric Return Visit Short Form**

Date \_\_\_\_\_

<b>1. Name:</b>		<b>AMPATH ID:</b>		<b>Previous ID:</b>	
<b>2. Age:</b> ___ Yrs. ___ Mo. <b>DOB:</b>		<b>3. Orphaned:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>4.</b> <input type="checkbox"/> Scheduled <input type="checkbox"/> Unscheduled	
<b>5. Location:</b> MTRH Module: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 Community Health Center: <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>6. Patient Category:</b> <input type="checkbox"/> Pilot <input type="checkbox"/> Hospital Waiver <input type="checkbox"/> Self Pay <input type="checkbox"/> Research <input type="checkbox"/> NASCOP		<b>7. Person Bringing Patient:</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> Auntie <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> Other _____	
<b>8. Current Feeding:</b> <input type="checkbox"/> Breast <input type="checkbox"/> Cow's milk <input type="checkbox"/> Expressed Breast milk <input type="checkbox"/> Formula <input type="checkbox"/> Predominate Breast <input type="checkbox"/> Mixed feeding <input type="checkbox"/> Weaned		<b>9. Previous Immunizations:</b> <input type="checkbox"/> HIB Dose#: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> BCG <input type="checkbox"/> DTP Dose#: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Measles Dose#: <input type="checkbox"/> 1 <input type="checkbox"/> HEP B Dose#: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Polio Dose#: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
<b>10. Has patient been hospitalized since last visit?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____					
<b>11. 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"/> 3TC (4mg/kg) <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> d4T <input type="checkbox"/> Tabs <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 30 <input type="checkbox"/> NVP <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> EFV <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> ABC (8mg/kg) <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> NFV <input type="checkbox"/> Powder ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> DDI (100mg/m2) <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> AZT <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg <input type="checkbox"/> Kaletra (0.125ml/kg) <input type="checkbox"/> Syrup ___ mg ___ ml <input type="checkbox"/> Tabs ___ mg					
<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 <input type="checkbox"/> Rifinah (Rifampin/INH) <input type="checkbox"/> Rifampicin <input type="checkbox"/> INH <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Ethambutol <input type="checkbox"/> Streptomycin <b>Start Date of TB treatment:</b> _____					
<b>Cryptococcus Tx:</b> <input type="checkbox"/> None <input type="checkbox"/> Diflucan					
<b>Other Drugs:</b>					
<b>12. Adherence:</b>					
<b>Who has been giving the medicine to the patient? (Please tick all that apply):</b> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent <input type="checkbox"/> Auntie <input type="checkbox"/> Self <input type="checkbox"/> Other (Specify): _____					
<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 Drug(s) Missed: _____ Reason: _____					
<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 _____					
Reasons for missing pills in the last 7 days: _____					
<b>13. Complaints</b>					
<b>Does the patient have any interval complaints?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Complaints: _____					
<b>14. Physical Exam:</b>					
<b>Vitals:</b> RR: P: Temp: Weight: Height: Head Circ: BSA: 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 <input type="checkbox"/> Edema		
<b>Exam Notes:</b>					
<b>RS:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify _____		<b>CNS:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify _____			
<b>CVS:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify _____		<b>MS:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify _____			
<b>PA:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify _____		<b>ENT:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Specify _____			
<b>15. Current Pediatric Staging:</b>					
<b>CDC Class:</b> <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C Criteria _____			New Stage <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>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		
<b>16. Test Results:</b> (Please record date test was drawn, rather than date test was run)					
<b>Test</b>	<b>Result</b>	<b>Test Date</b>	<b>Test</b>	<b>Result</b>	<b>Test Date</b>
WBC/mm <sup>3</sup>			CD4		
Hgb g/dL			CD8		
MCV			CD4%		
Platelets/ mm <sup>3</sup>			HIV Elisa		
ALC/ mm <sup>3</sup>			HIV DNA PCR		
SGPT			Viral Load		
Creat mmol/L			Other:		
CXR:	Code:		Codes: 0=normal 4=Diffuse abn/non-miliary 1=PI Effusion 5=Cavity 2=Infiltrate 6=Cardiomegaly 3=Miliary 7=Other abnormality		

