



<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			
<b>11. 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>			VDRL				
ALC/ mm <sup>3</sup>			Other				
SGPT							
Creat mmol/L							
CXR	Code		Codes: 0=normal      3=Miliary      6=Cardiomegaly 1=PI Effusion      4=Diffuse abn/non-miliary      7=Other abnormality 2=Infiltrate      5=Cavity				
<b>12. Impression:</b> New Problems							
* Tick "Add" to add a problem to summary sheet. Tick "Remove" to delete problem from summary sheet							
<b>Problem</b>	<b>Code</b>	<b>Add</b>	<b>Remove</b>	<b>Problem</b>	<b>Code</b>	<b>Add</b>	<b>Remove</b>
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_____							
<i>If start or change, tic new regimen:</i> 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 _____ tabs/day <input type="checkbox"/> Dapsone _____ mg/day							
<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"/> Rifafour _____ 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>							
<b>Drug</b>	<b>Dose</b>	<b>Freq &amp; Duration</b>	<b>Drug</b>	<b>Dose</b>	<b>Freq &amp; Duration</b>		
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):							
<b>Referrals:</b>							
<input type="checkbox"/> None <input type="checkbox"/> Social Support Services <input type="checkbox"/> Psychosocial counseling <input type="checkbox"/> Family Planning services <input type="checkbox"/> TB /DOT program <input type="checkbox"/> Disclosure counseling <input type="checkbox"/> Nutritional support <input type="checkbox"/> Adherence Counseling <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Other referral (specify):							
Return to Clinic: Weeks _____ Months _____ Date _____				CO/Physician: _____			
Hospitalization: <input type="checkbox"/> MTRH <input type="checkbox"/> Health Centre <input type="checkbox"/> Other: _____				Provider #: _____			
<b>For Community Clinics:</b> Medication picked-up at this visit: <input type="checkbox"/> Yes <input type="checkbox"/> No							