Documentation

December 2008

Department of Health - documents

- patients are not confined to one area (mobile – transport, employment etc.)
- HIV knows no boundaries
- patients move from clinic to clinic, hospital to hospital, Province to Province and even country to country
- *standardisation* of care important

Department of Health

National referral form

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME

TRANSFER OF ART PATIENT TO OTHER ART SERVICE POINT

Transfer to:
ART Service Point: _____
District/Metro: _____
DC No.: _____ Province: _____
Tel: _____ Fax: _____
Patient's contact details:

Transfer from: Public sector ☐ NGO/FBO/CBO ☐ GP ☐ Other non-public ☐
Facility Name: _____
District/Metro: _____
DC No.: _____ Province: _____
Tel: _____ Fax: _____
Mail address

PATIENT IDENTIFIER
First Name: _____ Surname: _____ Date of birth dd mm yy
Sex M ☐ F ☐ Tel: _____ Current file No: _____ ID
Parent/guardian: *(if applicable)* First Name: _____ Surname: _____ Tel: _____

PATIENT HISTORY

Baseline ART
ART start date dd mm yy
Regimen 1a ☐ Any child regimen ☐ *(if different to 1a or 1b)*
Regimen 1b ☐
Specify baseline ART regimen if not 1a or 1b:

Baseline Lab (at start of ART)
CD4 _____ % CD4 _____ cells/mm³

Baseline clinical status (at start of ART)
Weight (kg)
Height (cm)
WHO Clinical Stage Adult
WHO Clinical Stage Child

Current ART
Current regimen since mm yy
Regimen 1a ☐ Regimen 2 ☐
Regimen 1b ☐ Any child regimen ☐ *(if different to 1a/b or 2)*
Specify current ART regimen if not 1a/b or 2:
ART drugs issued will last until dd mm yy

Most recent Lab
CD4 _____ % mm yy
CD4 _____ cells/mm³
VL _____ copies/ml mm yy
ALT _____ U/l Ery _____ x10⁶/l
Hb _____ g/dl HCT _____ %
Leuc _____ x10³/l Lymph _____ x10³/l
Neut _____ x10³/l Platlet _____ x10³/l
Gluc _____ mmol/l Cholest _____ mmol/l

Current clinical status
Weight (kg)
WHO Clinical Stage Adult
WHO Clinical Stage Child

Current prophylaxis:
Cotrimoxazole No ☐ Yes ☐
Fluconazole No ☐ Yes ☐
Prophylaxis issued will last until dd mm yy

REASON FOR TRANSFER / other relevant details:

Past medical history including ARV adverse events

Transfer date dd mm yy
First appointment made at receiving service point No ☐ Yes ☐ Appointment date dd mm yy
Clinician's name _____ Signature _____ Tel _____ Fax _____

ACKNOWLEDGEMENT OF TRANSFER *(to be completed by receiving ART service point)*
We have received the transfer notice. Received date: dd mm yy
Please fax ☐ mail ☐ to us: ART Assessment and Baseline form ☐
Any previous Transfer forms ☐ ART Patient Follow Up forms/details ☐
Fax/send back copy of whole form to transferring ART service point immediately after receiving it!
Clinician's name _____ Tel _____ Fax _____

Patient has attended his/her first visit at our ART service point.
Date of visit: dd mm yy
Fax/send back copy of whole form to transferring ART service point immediately after first visit!
Clinician's name _____

Inform all patients to advise your clinic timeously if they intend transfering to another ARV site

Discharge with one month's supply of ARVs and this letter

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME

TRANSFER OF ART PATIENT TO OTHER ART SERVICE POINT

Transfer to:
ART Service Point: _____
District/Metro: _____
DC No.: _____ Province: _____
Tel: _____ Fax: _____
Patient's contact details:

Transfer from: Public sector ☐ NGO/FBO/CBO ☐ GP ☐ Other non-public ☐
Facility Name: _____
District/Metro: _____
DC No.: _____ Province: _____
Tel: _____ Fax: _____
Mail address:

PATIENT IDENTIFIER
First Name: _____ Surname: _____ Date of birth dd mm yy
Sex M ☐ F ☐ Tel: _____ Current file No: _____ ID
Parent/guardian: (if applicable) First Name: _____ Surname: _____ Tel: _____

PATIENT HISTORY

Baseline ART
ART start date dd mm yy
Regimen 1a ☐ Any child regimen ☐ (if different to 1a or 1b)
Regimen 1b ☐
Specify baseline ART regimen if not 1a or 1b:

Baseline Lab (at start of ART)
CD4 _____ % CD4 _____ cells/mm³

Baseline clinical status (at start of ART)
Weight (kg)
Height (cm)
WHO Clinical Stage Adult
WHO Clinical Stage Child

Current ART
Current regimen since mm yy
Regimen 1a ☐ Regimen 2 ☐
Regimen 1b ☐ Any child regimen ☐ (if different to 1a/b or 2)
Specify current ART regimen if not 1a/b or 2:
ART drugs issued will last until dd mm yy

Most recent Lab
CD4 _____ % mm yy
CD4 _____ cells/mm³
VL _____ copies/ml mm yy
ALT _____ U/l Ery _____ x10⁶/l
Hb _____ g/dl HCT _____ %
Leuc _____ x10³/l Lymph _____ x10³/l
Neut _____ x10³/l Platlet _____ x10³/l
Gluc _____ mmol/l Cholest _____ mmol/l

Current clinical status
Weight (kg)
WHO Clinical Stage Adult
WHO Clinical Stage Child

Current prophylaxis:
Cotrimoxazole No ☐ Yes ☐
Fluconazole No ☐ Yes ☐
Prophylaxis issued will last until dd mm yy

REASON FOR TRANSFER / other relevant details: _____

Transfer date dd mm yy
First appointment made at receiving service point No ☐ Yes ☐
Appointment date dd mm yy
Clinician's name _____ Signature _____ Tel _____ Fax _____

ACKNOWLEDGEMENT OF TRANSFER *(to be completed by receiving ART service point)*
We have received the transfer notice. Received date: dd mm yy
Please fax ☐ mail ☐ to us:
Any previous Transfer forms ☐ ART Assessment and Baseline form ☐ ART Patient Follow Up forms/details ☐
Fax/send back copy of whole form to transferring ART service point immediately after receiving it!
Clinician's name _____ Tel _____ Fax _____

Patient has attended his/her first visit at our ART service point.
Date of visit: dd mm yy
Fax/send back copy of whole form to transferring ART service point immediately after first visit!
Clinician's name _____

DoH National HIV referral form MUST include the following information:

CD4 results– baseline to present

Viral load results

Past and present ARV Treatment regimes

START DATE including restart dates if any

Side effects

Needed for future treatment decisions

MPL

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME - MPUMALANGA
ART ASSESSMENT AND BASELINE (CHILD: <15 years)

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME - MPUMALANGA
ART ASSESSMENT AND BASELINE (ADULT: 15 years and older)

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME - MPUMALANGA
ART FOLLOW UP (CHILD: <15 years)

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME - MPUMALANGA
ART PATIENT FOLLOW UP (ADULT: 15 years and older)

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME - MPUMALANGA
ART ASSESSMENT AND BASELINE (ADULT: 15 years and older)

Assessment visit 1 [ ][ ][ ][ ][ ][ ] *dd mm yy*

REFERRING SITE

Internal
In-patient [ ]
Out-patient [ ]

External
Public sector [ ]
Non-public sector [ ]

Referring Site _____
District/Metro _____ DC No.: _____
Province _____

CLINICAL AND LAB ASSESSMENT

Weight (kg) [ ][ ][ ] Height (cm) [ ][ ][ ]

WHO Clinical Stage 1 [ ]
WHO Clinical Stage 2 [ ]
WHO Clinical Stage 3 [ ]
WHO Clinical Stage 4 [ ]

Specify WHO Stage defining condition (s): _____

On TB treatment No [ ] Yes [ ] *if yes,* months [ ][ ] MDR TB No [ ] Yes [ ]
TB symptoms new No [ ] Yes [ ] *if yes,* smear 1 [ ][ ] *pos neg* smear 2 [ ][ ] *pos neg*

Prophylaxis: INK No [ ] Yes [ ] Cotrimoxazole No [ ] Yes [ ] Fluconazole No [ ] Yes [ ]
Previous ARV: PEP No [ ] Yes [ ] PMTCT No [ ] Yes [ ] ART interrupted No [ ] Yes [ ]

Other chronic disease No [ ] Yes [ ] *Specify:* _____
Other chronic medication No [ ] Yes [ ] *Specify:* _____

For woman only Pregnant No [ ] Yes [ ] Trimester [ ] Reliable contraception No [ ] Yes [ ]

HIV status documented No [ ] Yes [ ] VL _____ copies/ml VL result date [ ][ ][ ][ ][ ][ ] *dd mm yy*
If CD4 drawn at this service point
CD4 drawn date [ ][ ][ ][ ][ ][ ] *dd mm yy* CD4 _____ cells / mm^3 CD4 result date [ ][ ][ ][ ][ ][ ] *dd mm yy*
Hb _____ g/dl ALT _____ U/l Other _____

TREATMENT READINESS ASSESSMENT

Drug literacy training No [ ] Yes [ ] Nutritional assessment No [ ] Yes [ ] Home visit done No [ ] Yes [ ]
Adherence training No [ ] Yes [ ] Social worker consultation No [ ] Yes [ ] Disclosure No [ ] Yes [ ]

MULTIDISCIPLINARY TEAM DECISION

Medical criteria (CD4<200 and/or WHO Stage 4) fulfilled No [ ] Yes [ ] Treatment supporter No [ ] Yes [ ]
Medical criteria fulfilled but patient died during assessment No [ ] Yes [ ] Details (name, telephone etc)
Patient expresses willingness to take ART adherently No [ ] Yes [ ]
Any medical reason for delay of ART start No [ ] Yes [ ]
Decision of multidisciplinary team: Start ART No [ ] Yes [ ]

ART START

AAR start date [ ][ ][ ][ ][ ][ ] *dd mm yy*

Regimen 1a [ ]
Regimen 1 b [ ]

Specify ART drugs and dose if not regimen 1a or 1b:

Notes:

Total number of assessment visits [ ]
(including ART commencement visit)

Next scheduled visit [ ][ ][ ][ ][ ][ ] *dd mm yy*

Clinician's name _____ Signature _____ Tel: _____

Data captured
Date _____
Initials

NATIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME - MPUMALANGA
ART ASSESSMENT AND BASELINE (CHILD: <15 years)

Assessment visit 1 [ ][ ] [ ][ ] [ ][ ] (dd mm yy)

REFERRING SITE

Internal
In-patient [ ]
Out-patient [ ]

External
Public sector [ ]
Non-public sector [ ]

Referring Site _____
District/Metro _____ DC No.: _____
Province _____

CLINICAL AND LAB ASSESSMENT

Weight (kg) [ ][ ][ ] Height (cm) [ ][ ][ ] BSA [ ] . [ ][ ]

WHO Clinical Stage 1 (child) [ ]
WHO Clinical Stage 2 (child) [ ]
WHO Clinical Stage 3 (child) [ ]
Specify WHO Stage defining condition (s): _____

On TB treatment No [ ] Yes [ ] *if yes,* months [ ][ ] MDR TB No [ ] Yes [ ]
TB symptoms new No [ ] Yes [ ] *if yes,* smear 1 [ ][ ] *pos neg* smear 2 [ ][ ] *pos neg*

Prophylaxis: INK No [ ] Yes [ ] Cotrimoxazole No [ ] Yes [ ] Fluconazole No [ ] Yes [ ]
Previous ARV: PEP No [ ] Yes [ ] PMTCT No [ ] Yes [ ] ART interrupted No [ ] Yes [ ]

Other chronic disease No [ ] Yes [ ] *Specify:* _____
Other chronic medication No [ ] Yes [ ] *Specify:* _____

HIV status documented No [ ] Yes [ ] VL _____ copies/ml VL result date [ ][ ] [ ][ ] [ ][ ] (dd mm yy)
If CD4 drawn at this service point
CD4 drawn date [ ][ ] [ ][ ] [ ][ ] (dd mm yy) CD4 _____ % CD4 _____ cells / mm^3 CD4 result date [ ][ ] [ ][ ] [ ][ ] (dd mm yy)

Hb _____ g/dl HCT _____ 1/1 Leuc _____ $x10^9/1$ Lymph _____ $x10^9/1$ Fasting glucose _____ mmol/l
ALT _____ U/l Ery _____ $x10^{12}/1$ Neut _____ $x10^9/1$ Platlet _____ $x10^9/1$ Fasting cholesterol _____ mmol/l

TREATMENT READINESS ASSESSMENT (together with parent/guardian)

Drug literacy training No [ ] Yes [ ] Nutritional assessment No [ ] Yes [ ] Home visit done No [ ] Yes [ ]
Adherence training No [ ] Yes [ ] Social worker consultation No [ ] Yes [ ] Disclosure No [ ] Yes [ ]

MULTIDISCIPLINARY TEAM DECISION

Medical criteria (CD4 / clinical stage / hospitalization) fulfilled No [ ] Yes [ ] Treatment supporter No [ ] Yes [ ]
Medical criteria fulfilled but patient died during assessment No [ ] Yes [ ] Details (name, telephone etc)
Patient expresses willingness to take ART adherently N/A [ ] No [ ] Yes [ ]
Parents (s) / guardian support (s) ART No [ ] Yes [ ]
Any medical reason for delay of ART start No [ ] Yes [ ]
Decision of multidisciplinary team: Start ART No [ ] Yes [ ]

ART START

AAR start date [ ][ ] [ ][ ] [ ][ ] (dd mm yy)
Regimen 1a [ ] Any child regimen [ ]
Regimen 1 b [ ] (If DRUGS different to la/b)

Specify ART drugs and dose if not regimen 1a or 1b:

Notes:

Total number of assessment visits [ ]
(including ART commencement visit)

Next scheduled visit [ ][ ] [ ][ ] [ ][ ] (dd mm yy)

Clinician's name _____ Signature _____ Tel: _____

Data captured
Date _____
Initials _____

EC

KZN

WC