

IDCAP HIV/ART Clinical Observation – Patient Form

Site #:	Trainee #:
Observer #:	Date of visit (d/m/y):
Triage status: <input type="checkbox"/> Emergency identified by clinic team <input type="checkbox"/> Emergency missed by clinic team <input type="checkbox"/> Not Emergency	
If emergency, stop observation and support trainee to manage patient. Then complete emergency case report.	

Language of patient during visit (other than English): _____ Translation? Yes No

Gender of patient: F M Age of patient: _____ months (LT 5 years) _____ years (GE 5 years)

I. Vital signs: Reported by other health professional before consultations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Temperature _____ C/F If no thermometer, febrile to touch <input type="checkbox"/> Y <input type="checkbox"/> N Current weight _____ kg Weight last visit _____ kg Peak weight _____ kg Height _____ cm BP _____	<input type="checkbox"/> NE <input type="checkbox"/> NE

Clinician washes hands before consultation? Yes No Clinician greets patient/friend warmly? Yes No

II. Current ART: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NR If yes, start date? (d/m/y) ___/___/___	Is result of HIV test confirmed positive? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, test? <input type="checkbox"/> Ab (HIV antibody) <input type="checkbox"/> Ag/PCR (child less than 18 months)
Medication: If current ART, regimen: <input type="checkbox"/> 3TC <input type="checkbox"/> AZT <input type="checkbox"/> d4T <input type="checkbox"/> TDF <input type="checkbox"/> FTC <input type="checkbox"/> NVP <input type="checkbox"/> EFV Previous exposure to ARV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NR If Yes: <i>Indication:</i> <input type="checkbox"/> PEP <input type="checkbox"/> PMTCT <input type="checkbox"/> Other _____ <input type="checkbox"/> TB active (<input type="checkbox"/> intensive phase <input type="checkbox"/> continuation phase) <input type="checkbox"/> Previous TB; Date (d/m/y) last dose ___/___/___ <input type="checkbox"/> CTX preventive <input type="checkbox"/> Other (specify) _____	
Allergy to Medication: <input type="checkbox"/> None <input type="checkbox"/> CTX <input type="checkbox"/> SP <input type="checkbox"/> Other _____ <input type="checkbox"/> NR	
Additional history: <input type="checkbox"/> None <input type="checkbox"/> Previous OI (specify) _____ <input type="checkbox"/> NR	
If female, now pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NR <input type="checkbox"/> Suspected, not confirmed LNMP: ___/___/___	

III. History	Patient	Clinician	Patient	Clinician
Fever:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	ART adherence:	
Duration _____ days			How many taken? _____ pills <input type="checkbox"/> NR	<input type="checkbox"/> NH
Coughing:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	How many prescribed? _____ pills <input type="checkbox"/> NR	<input type="checkbox"/> NH
Duration _____ days			Side effects of drugs	
Night sweats:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Specify _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR
Weight loss:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH		
Specify % _____			Karnofsky score	
Recent contact with someone who has TB:	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Able to work <input type="checkbox"/>	<input type="checkbox"/> NH
			Ambulatory <input type="checkbox"/>	
			Bedridden <input type="checkbox"/>	
			% of the time: _____	

Clinician asks patient about other current symptoms or concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No (Enter Y, N or V below.)				<input type="checkbox"/> NH
Abdominal pain <input type="checkbox"/>	Convulsions <input type="checkbox"/>	Headache <input type="checkbox"/>	Skin lesions <input type="checkbox"/>	
Anxiety <input type="checkbox"/>	Depression <input type="checkbox"/>	Loss of appetite <input type="checkbox"/>	Skin Rash <input type="checkbox"/>	
Breathing – shortness of breath <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	Mouth problems <input type="checkbox"/>	Swallowing difficulty <input type="checkbox"/>	
Burning, tingling, loss/change sensation <input type="checkbox"/>	Duration _____ days Blood? <input type="checkbox"/> Y <input type="checkbox"/> N	Myalgias <input type="checkbox"/>	Vomiting <input type="checkbox"/>	
Chest pain <input type="checkbox"/>	Fatigue <input type="checkbox"/>	Nausea <input type="checkbox"/>	Other (specify): <input type="checkbox"/>	
	Genital problem <input type="checkbox"/>	Skin itching <input type="checkbox"/>		

IV. Physical examination

General	<input type="checkbox"/>	{ <input type="checkbox"/> normal <input type="checkbox"/> agitation <input type="checkbox"/> fat change(lipodystrophy) <input type="checkbox"/> jaundice <input type="checkbox"/> lymphadenopathy <input type="checkbox"/> oedema <input type="checkbox"/> pallor <input type="checkbox"/> wasting <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Skin	<input type="checkbox"/>	{ <input type="checkbox"/> normal <input type="checkbox"/> abscess <input type="checkbox"/> ecchymosis <input type="checkbox"/> erythema <input type="checkbox"/> herpes zoster scar <input type="checkbox"/> Kaposi <input type="checkbox"/> nodules <input type="checkbox"/> papules <input type="checkbox"/> pus <input type="checkbox"/> pustules <input type="checkbox"/> scaling <input type="checkbox"/> vesicles <input type="checkbox"/> wound <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Mouth	<input type="checkbox"/>	{ <input type="checkbox"/> normal <input type="checkbox"/> abscess <input type="checkbox"/> candida <input type="checkbox"/> gingivitis <input type="checkbox"/> Kaposi <input type="checkbox"/> ulcers <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Lungs	<input type="checkbox"/>	{ <input type="checkbox"/> clear <input type="checkbox"/> crackles <input type="checkbox"/> dyspnea <input type="checkbox"/> diminished <input type="checkbox"/> in-drawing <input type="checkbox"/> retractions <input type="checkbox"/> rhonchi <input type="checkbox"/> wheezes <input type="checkbox"/> RR (only if cough or dyspnea)_____ <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Cardio-vascular	<input type="checkbox"/>	<input type="checkbox"/> pulse_____ <input type="checkbox"/> gallop <input type="checkbox"/> murmur <input type="checkbox"/> rub <input type="checkbox"/> other_____	<input type="checkbox"/> NE
Abdo-men	<input type="checkbox"/>	{ <input type="checkbox"/> normal <input type="checkbox"/> abnormal sound <input type="checkbox"/> ascites <input type="checkbox"/> distended <input type="checkbox"/> hepatomegaly <input type="checkbox"/> mass <input type="checkbox"/> organomegaly <input type="checkbox"/> pregnancy <input type="checkbox"/> splenomegaly <input type="checkbox"/> tenderness <input type="checkbox"/> other _____ For findings, note where _____	<input type="checkbox"/> NE
Genita-lia	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> discharge <input type="checkbox"/> tenderness <input type="checkbox"/> ulcers <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Muculo skeletal	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Neuro	<input type="checkbox"/>	{ <input type="checkbox"/> benign <input type="checkbox"/> coma <input type="checkbox"/> confusion, disorientation <input type="checkbox"/> focal deficit <input type="checkbox"/> meningismus <input type="checkbox"/> paresthesia <input type="checkbox"/> seizure <input type="checkbox"/> other _____	<input type="checkbox"/> NE
Other	<input type="checkbox"/>	Specify exam and findings _____	<input type="checkbox"/> NE

V. Laboratory or imaging studies with results reviewed by clinician: Not available Not reviewed

Ab(HIV antibody) Ag/PCR(child less than 18 months) Hemoglobin CBC(hemogram) CD4

CXR Creatinine Glucose HepB LFT (transaminases) Malaria BS Malaria RDT

Pregnancy RPR TB sputum Viral load Other _____

CD4 Result? _____ Date (d/m/y) of last CD4 ____/____/____

CD4 Result? _____ Date (d/m/y) of CD4 ____/____/____

CD4 Result? _____ Date (d/m/y) of CD4 ____/____/____

Describe abnormal or other clinically important results: _____

What is the highest confirmed WHO clinical disease stage for this patient: I II III IV

What is the basis for this staging decision? OI (specify) _____

Date (d/m/y) of staging diagnosis ____/____/____

Stop consultation and confer with trainee before completing the treatment plan.

VIII. PLAN:

CTX: Start Stop Continue

Positive prevention message: Yes No

Recommend Mosquito Net: Yes No NA

Refer: Where _____

OI Tx: Specify: _____

Tx Other conditions (e.g. malnutrition):
Specify _____

ART: Continue Start Stop Modify

If change, new regimen: 3TC AZT d4T TDF FTC NVP EFV Other _____

Reason: _____

Laboratory tests: _____

Radiology: CXR Other _____

Date of next visit: ____/____/____

Observation #: _____

IDCAP Outpatient Clinical Observation – Form for child less than 5 years

Site #:	Trainee #:
Observer #:	Date of visit (d/m/y):
Triage status: <input type="checkbox"/> Emergency identified by clinic team <input type="checkbox"/> Emergency missed by clinic team <input type="checkbox"/> Not Emergency	
If emergency, stop observation and support trainee to manage patient. Then complete emergency case report.	

Type of visit: New attendance Re-attendance

Language of patient during visit (other than English): _____ Translation? Yes No

Gender of patient: F M Age of patient: _____ months Date of birth: (d/m/y): _____

I. Vital signs: Reported by other health professional before consultations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Temperature _____ C/F If no thermometer, febrile to touch <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> NE
Current weight _____ kg height _____ cm Weight last visit _____ kg Date last visit(d/m/y): ___/___/___	<input type="checkbox"/> NE

Clinician washes hands before consultation? Yes No

Clinician greets patient/friend warmly? Yes No

What are the child's complaints? cough/difficulty breathing diarrhea ear pain fever HIV exposed
 vomiting other (Specify) _____

II. History Does the patient have danger signs? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR If yes, specify <input type="checkbox"/> Change in consciousness/lethargic <input type="checkbox"/> NH <input type="checkbox"/> Convulsions <input type="checkbox"/> Not able to drink/breastfeed <input type="checkbox"/> Vomits everything <input type="checkbox"/> Other _____					
	Patient	Clinician		Patient	Clinician
Fever?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Coughing?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
Duration	_____ days <input type="checkbox"/> NR	<input type="checkbox"/> NH	Duration	_____ days <input type="checkbox"/> NR	<input type="checkbox"/> NH
Antimalarials before today's visit?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Night sweats?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
Measles within the last 3 months?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Weight loss? Specify % _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
Ear pain?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Recent contact with someone who has TB?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
Duration	_____ days <input type="checkbox"/> NR		Diarrhea?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
Ear discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Duration	_____ days <input type="checkbox"/> NR	<input type="checkbox"/> NH
Duration	_____ days <input type="checkbox"/> NR	<input type="checkbox"/> NH	Blood?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
HIV status?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH	Vaccination card?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH
Trainee asks patient about other current symptoms or concerns? If yes, specify response _____				<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NR	<input type="checkbox"/> NH

III. Physical examination				
Danger Sign	<input type="checkbox"/>	<input type="checkbox"/> none <input type="checkbox"/> lethargic <input type="checkbox"/> not able to drink or breastfeed <input type="checkbox"/> drinks eagerly/thirsty	<input type="checkbox"/> NE	
Growth	<input type="checkbox"/>	<input type="checkbox"/> low weight for age against weight chart <input type="checkbox"/> low weight for age not improving <input type="checkbox"/> missed or lost developmental milestone	<input type="checkbox"/> NE	
General	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> eyes, red <input type="checkbox"/> eyes, sunken <input type="checkbox"/> jaundice <input type="checkbox"/> lymphadenopathy <input type="checkbox"/> oedema <input type="checkbox"/> pallor <input type="checkbox"/> runny nose <input type="checkbox"/> restless, irritable <input type="checkbox"/> wasting <input type="checkbox"/> other _____	<input type="checkbox"/> NE	
Skin	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> generalized rash <input type="checkbox"/> other _____	<input type="checkbox"/> NE	
CNS	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> abnormal muscle tone <input type="checkbox"/> abnormal reflexes <input type="checkbox"/> stiff neck <input type="checkbox"/> other _____	<input type="checkbox"/> NE	
Ear	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> pus/drainage <input type="checkbox"/> swelling behind ear <input type="checkbox"/> other _____	<input type="checkbox"/> NE	
Lungs	<input type="checkbox"/>	<input type="checkbox"/> clear <input type="checkbox"/> cough <input type="checkbox"/> chest in-drawing <input type="checkbox"/> stridor <input type="checkbox"/> RR _____ <input type="checkbox"/> other _____	<input type="checkbox"/> NE	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> abnormal pinch skin <input type="checkbox"/> other _____	<input type="checkbox"/> NE	
Other	<input type="checkbox"/>	<input type="checkbox"/> Specify exam and findings _____	<input type="checkbox"/> NE	

Stop consultation and confer with trainee. Complete remaining sections based on final diagnosis and treatment.

Did trainee order laboratory investigations? Yes No If yes, did patient return with results? Yes No NA
If yes, Describe abnormal results. _____

VI. Diagnosis: <input type="checkbox"/> One or more danger signs <input type="checkbox"/> Anaemia <input type="checkbox"/> Cough (no pneumonia) <input type="checkbox"/> Diarrhea – acute <input type="checkbox"/> Diarrhea – persistent <input type="checkbox"/> Dysentery	<input type="checkbox"/> Ear infection <input type="checkbox"/> HIV infection <input type="checkbox"/> HIV suspect <input type="checkbox"/> Malaria (uncomplicated) <input type="checkbox"/> Malaria (complicated) <input type="checkbox"/> Malnutrition (low weight for age) <input type="checkbox"/> Severe malnutrition	<input type="checkbox"/> Measles <input type="checkbox"/> Meningitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> TB infection <input type="checkbox"/> TB suspect <input type="checkbox"/> Other (Specify) _____
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VII. Plan: Malaria tx: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment was prescribed? _____ Route: <input type="checkbox"/> oral <input type="checkbox"/> parenteral <i>(Refer to score sheet with Antimalarial codes)</i> Antibiotic tx: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment was prescribed? _____ Route: <input type="checkbox"/> oral <input type="checkbox"/> parenteral <i>(Refer to score sheet with Antibiotic codes)</i> Tx other conditions (e.g. TB, malnutrition): Specify _____ Refer: <input type="checkbox"/> Where _____ Radiology: <input type="checkbox"/> CXR <input type="checkbox"/> Other _____ Date of next visit: ____/____/____	CTX prophylaxis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Recommend Mosquito Net: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Vitamin A: <input type="checkbox"/> Yes <input type="checkbox"/> No Update immunizations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Did trainee: Provide information to parent or guardian about diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Explain treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA Provide instructions on how to complete treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
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