PPCT POSITIVE IN PREGNANCY FORM

DATE:_____/_____/_____
DD MM YYYY

NAME:	PSC Patient ID:	ANTENATAL ID:	SITE:

Date of Birth: _____/____/_____ DD MM YYYY	If birth date unknown, age at last birth day: ____ years

SOCIAL/DEMOGRAPHIC HISTORY:

Date of 1st positive HIV test: _____/_____/_____ DD MM YYYY	Has your partner been tested for HIV? ☐ Yes ☐ No ☐ N/A	
What is your occupation? _____	Do you (or your family) generally have enough money to cover your expenses? ☐ Yes ☐No	
What is your marital status? ☐ Single ☐ Widowed/single ☐Widowed/married ☐ Married/living together → male, number of wives_____ →female, number of co-wives_____	Highest level of education ☐ None ☐ Some primary ☐ Some secondary ☐ Some college/university	How many people usually live in your household including yourself? _____ Children under 5 years of age? _____ Children between 5 and 14 years of age_____ Individuals that are 15 years of age or older? _____

DISCLOSURE

Have you disclosed your HIV status to anyone? ☐ Yes ☐No
To whom? ☐ Partner/spouse ☐Friend ☐Relative ☐ Other (specify): _____

OBSTETRIC HISTORY

Enter number of: Total pregnancies _____ Live births _____ Miscarriages_____ Currently living_____ (if none-> mark 0)	LMP _____/_____/_____ DD MM YYYY How many months are you currently pregnant? _____	**EDD:** _____/_____/_____ DD MM YYYY **REFER TO MOH MOTHERS HEALTH CARD FOR ANATENAL CARE**

PAST MEDICAL AND SURGICAL HISTORY

☐ Diabetes ☐Hypertension ☐PreEclampsia/Toxemia ☐Cesarean ☐4th degree Laceration/fistula
Other:_____
_____

TB HISTORY	Has the patient been treated for TB before? ☐Yes ☐No If yes, year_____ Is the patient currently being treated for TB? ☐Yes ☐No Any household member previously/currently treated for TB? ☐Yes ☐No

PHYSICAL EXAMINATION

VITALS	EXAMINATION	COMMENTS/DESCRIPTION
Temp: _____ o C Pulse: _____ b/min BP: ___/___ mmHg Weight:_____Kg Height: _____cm Resp. rate:_____ breaths/min	Eyes, Ears, Nose, Throat	
	Lymph Nodes	
	Respiratory	
	Cardiovascular	
	Gastrointestinal	
	Neurological	
	Musculoskeletal	
	Genitourinary	
	Skin	
	Other	

WHO ADULT HIV STAGING SYSTEM	
WHO ADULT STAGE 1	
◻ Asymptomatic HIV Infection	◻ Persistent Generalized Lymphadenopathy (PGL)
WHO ADULT STAGE 2	
◻ Moderate weight loss (<10% of presumed or measured body weight) ◻ Minor mucocutaneous manifestations (seborrheic dermatitis, prurigo, fungal infection, recurrent oral ulcerations, angular cheilitis	◻ Herpes Zoster past or recurrent within last 2 years ◻ Recurrent or chronic upper respiratory tract infections (bacterial sinusitis, bronchitis, otitis media pharyngitis)
WHO ADULT STAGE 3	
◻ Severe weight loss (> 10% of presumed or measured body weight) ◻ Unexplained chronic diarrhea > 1 month ◻ Unexplained prolonged fever > 1 month ◻ Oral candidiasis (Thrush)	◻ Oral hairy leukoplakia (OHL) ◻ Pulmonary tuberculosis (PTB) in last year ◻ Severe bacterial infections (e.g. pneumonia, pyomyositis, empyema, bone or joints infections)
WHO ADULT STAGE 4	
◻ HIV wasting syndrome (Severe weight loss and either unexplained chronic diarrhea or unexplained prolonged fever > 1 month) ◻ Pneumocystis carinii pneumonia ◻ Recurrent severe bacterial pneumonia (>/=2 episodes within 1 year) ◻ Cryptococcal meningitis, cryptococcosis ◻ Toxoplasmosis of the brain ◻ Chronic orolabial, genital or ano-rectal herpes simplex virus infection > 1 month ◻ Kaposi's sarcoma ◻ HIV encephalopathy ◻ Extra pulmonary tuberculosis (EPTB) ◻ Cryptosporidiosis with diarrhea > 1 month	◻ Isosporiasis ◻ Disseminated non-tuberculous mycobacterial infection ◻ Cytomegalovirus (CMV) retinitis or disease of the ◻ Progressive multifocal leukoencephalopathy (PML) ◻ Any disseminated endemic mycosis (e.g. histoplasmosis) ◻ Candidiasis of the oesophagus or airways ◻ Non-typhoid salmonella (NTS) septicaemia ◻ Primary CNS lymphoma or B cell NHL

Based on history and physical examination, indicate the most advanced WHO stage: O 1 O 2 O 3 O 4

INVESTIGATIONS ORDERED TODAY	
☐ HB ☐Blood group/RH ☐ VDRL	☐UA ☐MPS ☐ CD4

MEDICATIONS PRESCRIBED TODAY		
ARVS: ☐NVP ☐AZT ☐Other ARVS _____, _____, _____, _____		
O Multivitamin O Iron/folate O TT	O CTX O Albendazole O Malaria IPT	O Food by prescription O Anti TB medications _____, _____, _____, _____

WHAT REFERRALS WILL BE MADE FOR THE PATIENT?		
☐None	☐TB treatment/DOT program	☐ PSC for HIV care
☐Social Support groups	☐Nutritional services	☐Inpatient care/Hospitalization
☐Other referral, specify:_____		

Follow up issues for next visit:

Next Scheduled Appointment Date	Form completed by:
_____ / _____ / _____ DD MM YYYY	CCHA_____ Nurse_____ Clinical Officer_____ Medical Officer _____