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

Temp: ______ o C
Pulse: ______ b/min
BP: ___/___ mmHg
Weight:______Kg
Height: ______cm
Resp. rate:__________ breaths/min

EXAMINATION	COMMENTS/DESCRIPTION
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 ______ / ______ / ________ DD MM YYYY	**Form completed by:** CCHA______________________________ Nurse______________________________ Clinical Officer_____________________ Medical Officer _____________________