HIV Care/ART Card—Summary Page

Unique # ☐☐☐☐☐☐

HIV CARE/ART CARD ____

District_____Health Unit_____ District clinician/team_____

Name_____Pt Clinic No._____
Sex: M ☐ F☐ Age _____DOB_____Marital status_____
Address_____

_____
Phone(whose):

Prior ART: ☐Transfer in with records ☐PMTCT only
☐ Earlier ARV, not transfer in ☐ None

Care entry point:PMTCT Medical Outpatient Under5 TB STI Private/Co Inpatient IDU Outreach Adol Sex Self-refer CBO Other:

Treatment supporter/med pick-up if ill:_____
Address_____
Phone:
Home-based care provided by:

Names of family members also in care	Age	HIV status	Unique No.

ART treatment interruptions			
Stop Lost (circle)	**Date**	**Why**	**Date if Restart:**
Stop Lost			
Stop Lost			
Stop Lost			
Stop Lost			

Date

_____ Confirmed HIV+ test Where_____ HIV 1 2 Ab / PCR if < 18 mo

_____ Enrolled in HIV care

ARV Therapy

COHORT:

_____ Medically eligible Clinical stage_____
Why eligible: ☐Clinical only ☐ CD4 #/%_____ ☐ TLC_____

_____ Medically eligible and ready for ART

_____ Transferred in from _____ART started_____

1st- line

_____**Start ART first-line– initial regimen:**_____

At start ART: Weight _____Function ___ Clinical stage___

_____ **Substitute within first-line:**

_____ New regimen_____ Why___

_____ New _____ Why___

2nd-line

Switch to 2nd line (or Substitute within 2nd line):

_____ New regimen_____Why____

_____ New_____Why___

_____ New_____Why___

_____ **Dead**

_____ **Transferred out** To where:_____

Why STOP codes:
1 Toxicity/side effects
2 Pregnancy
3 Treatment failure
4 Poor adherence
5 Illness, hospitalization
6 Drugs out of stock
7 Patient lack finances
8 Other patient decision
9 Planned Rx interruption
10 Other

Why SUBSTITUTE or SWITCH codes:
1 Toxicity/ side effects
2 Pregnancy
3 Risk of pregnancy
4 Due to new TB
5 New drug available
6 Drug out of Stock
7 0ther reason (specify)
Reasons for **SWITCH** to 2nd-Line Regimen only:
8 Clinical treatment failure
9 Immunologic failure
10 Virologic failure

HIV Care/ART Card—Encounter Page

Unique # ☐☐☐☐☐ **HIV CARE/ART CARD ____** **Name**_____

Date Check if scheduled. Write in alternate pick-up if ill	Follow-up Date	Duration since first starting ART/ since starting current regimen	**Wt**	**Pregnant** PMTCT? Due date or **FP**— no FP/ yes: Methods ___ **If child: Height**	Func-tion **W**ork **A**mb **B**ed	**WHO** Clinical **Stage**	TB Status	Potential SIDE EFFECTS	New OI, Other PROBLEMS	Cotrimoxazole **A**dhere /**D**ispense		Other meds dispensed	**ARV drugs** **A**dherence	**D**ispense	CD4	Hgb, RPR, TLC, other lab	Refer or consult or link/ provide Hospital days- no.
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