HIV CARE REPORT

BC

The Law on Reporting Disease (R.A. 3573) & the Philippine AIDS Prevention and Control Act (R.A. 8504) requires physicians to report all diagnosed HIV infections to the HIV & AIDS Registrar at the Epidemiology Bureau, DOH. Please write in CAPITAL LETTERS and CHECK the appropriate boxes.

VISIT INFO

HIV Confirmatory Code: _____ **Patient code:** _____

Date of visit: (MM / DD / YYYY) _____ Physician's name: _____

Visit type: ☐ First consult at this facility; trans-in from: _____ *(HIV treatment facility)* Facility name: _____

☐ Follow-up Facility address: _____

☐ Inpatient Facility contact #: _____

IF FIRST VISIT

If this is the patient's <u>first care visit at this facility</u>, please fill out this section:

UIC: __ __ | __ __ | __ __ | __ __ __ __ __ __ __ __ **Philhealth No.:** _____

* UIC: First two letters of mother's name, first two letters of father's name, two-digit birth order, birthdate (MM-DD-YYYY)

Patient's full name: _____ **Sex (at birth):** ☐ M ☐ F **History of PreP:** ☐

Current residence: City/Municipality: _____ Province: _____

KP Class: ☐ MSM ☐ TGP ☐ SW ☐ IDU ☐ Partner of KP

Already diagnosed with <u>current active TB</u> by another facility? ☐ Yes ☐ No

Already on treatment for <u>current active TB</u> prior to this visit? ☐ Yes ☐ No

WHO Classification: ☐ I ☐ II ☐ III ☐ IV

LABORATORY TESTS

Latest results	**Date done**	**Results**		**Date done**	**Results**	
Viral load			copies/mL	Creatinine		µmol/L
CD4 count			cells/µL	HBsAg		IU/mL
Chest X-ray						
Gene Xpert						
HIVDR & Genotype						

TB INFORMATION

Presence of at least one of the following: weight loss, cough, night sweats, fever? ☐ Yes ☐ No

<u>No active TB</u>

IPT Status: ☐ Started IPT this visit ☐ Ended IPT this visit

☐ Ongoing IPT

☐ Not on IPT

IPT outcome (if ended IPT this visit):

☐ Completed

☐ Stopped before target end

☐ Other: _____

<u>With active TB</u>

Site: ☐ Pulmonary ☐ Extrapulmonary

Drug resistance: ☐ Susceptible ☐ MDR ☐ XDR

☐ RR only ☐ Other: _____

TB treatment status: ☐ Ongoing ☐ Completed

☐ Not on tx ☐ Other: _____

TB tx outcome (if ended this visit): ☐ Cured ☐ Failed ☐ Not yet evaluated ☐ Other: _____

OI

Infections currently present (check all that apply):

☐ Hepatitis B ☐ Pneumocystis pneumonia (PCP) ☐ Oropharyngeal candidiasis

☐ Hepatitis C ☐ CMV retinitis ☐ Others (specify) _____

Currently taking: ☐ Cotrimoxazole prophylaxis ☐ Azithromycin prophylaxis

OB

Currently pregnant: ☐ No ☐ Yes; Age of gestation: _____ If delivered, date of delivery: _____

Type of infant feeding: ☐ Breastfeeding ☐ Formula feeding ☐ Mixed feeding

ART REGIMEN

ART Status:

☐ Enrolling this visit

☐ Continuing

☐ Not on ART

Reason if not on ART: _____

Drug	**# of pills per day**	**# pills missed (past 30 days)**	**# of pills left**	**Date discontinued**	**Reason (D/C code)**

HACT Physician approval: _____

Discontinuation codes:
1- Treatment Failure
2-Clinical progression/hospitalization
3-Patient Decision/Request
4-Compliance difficulties
5-Drug Interaction
6-Adverse Event (Specify)
7-Others (Specify)
8-Death

PHARMACY

Date Dispensed	**Drug**	**# of pills on hand**	**# of pills dispensed**

Dispensed by: _____