

# MCAP PEDIATRIC FOLLOW-UP FORM

Patient Name: \_\_\_\_\_ Patient ID Number:

Visit Date:  /  /      
 day month year

1. What is the child's current HIV status?     HIV-infected     HIV-exposed, infection status unknown
2. Does the patient have a new medical problem, physical symptom, or concern today?  Yes     No  
 If yes, please describe:
3. Within the last month, has the patient experienced any of the following symptoms?  Yes     No  
 If yes, fill in the 'o' to the right of each condition. If no, proceed to question 4.

Symptom	Yes	Symptom	Yes
Cough	<input type="radio"/>	Numbness or tingling in legs and/or feet	<input type="radio"/>
Depression	<input type="radio"/>	Pain - Abdominal	<input type="radio"/>
Diarrhea	<input type="radio"/>	Pain - Muscles	<input type="radio"/>
Difficulty breathing	<input type="radio"/>	Pain - Legs/feet	<input type="radio"/>
Fatigue	<input type="radio"/>	Poor appetite	<input type="radio"/>
Fever	<input type="radio"/>	Rash	<input type="radio"/>
Headache	<input type="radio"/>	Thrush	<input type="radio"/>
Learning/education problems (if applicable)	<input type="radio"/>	Weakness	<input type="radio"/>
Memory problems	<input type="radio"/>	Weight loss / failure to thrive	<input type="radio"/>
Nausea and/or vomiting	<input type="radio"/>	Other 1 (specify):	<input type="radio"/>
New visual problems	<input type="radio"/>	Other 2 (specify):	<input type="radio"/>
Night sweats	<input type="radio"/>	Other 3 (specify):	<input type="radio"/>

4. Physical examination

Temperature   °C    Length/Height   cm    Weight   kg    Head Circumference   cm

Examinations	Normal	Abnormal	Not Done	Comments / Descriptions
Ears, nose, throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Head and neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cardiovascular	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lungs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lymph nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Urogenital	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Musculoskeletal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Neurological	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Developmental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Tanner staging (if applicable)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Other 1 (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

5. Does the patient meet appropriate developmental milestones?  Yes     No  
 5a. If no, has the patient lost any developmental milestones?  Yes     No

See Clinical Manual for developmental milestones

6. Is the patient currently attending school?  Yes     No     Not applicable (child not school age)  
 Comments:

7. Is the patient currently being breastfed?  Yes  No  
 7a. If yes, is the child receiving any foods or liquids other than breast milk (including water)?  Yes  No
8. If HIV-infected, has the patient been hospitalized since the last visit, for HIV-related reasons?  Yes  No  
 If so, briefly describe the reason for hospitalization:

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9. If HIV-infected, what is the highest WHO staging indicator condition the patient has experienced to date?  
 WHO Stage 1  WHO Stage 2  WHO Stage 3

WHO stage I*	WHO stage II*	WHO stage III*
<ul style="list-style-type: none"> <li>▪ Asymptomatic</li> <li>▪ Generalized lymphadenopathy</li> </ul>	<ul style="list-style-type: none"> <li>▪ Unexplained chronic diarrhea</li> <li>▪ Severe persistent or recurrent candidiasis outside the neonatal period</li> <li>▪ Weight loss or failure to thrive</li> <li>▪ Persistent fever</li> <li>▪ Recurrent severe bacterial infections</li> </ul>	<ul style="list-style-type: none"> <li>▪ AIDS-defining opportunistic infection</li> <li>▪ Severe failure to thrive</li> <li>▪ Progressive encephalopathy</li> <li>▪ Malignancy</li> <li>▪ Recurrent septicaemia or meningitis</li> </ul>

\* use locally modified staging where appropriate

10. Since the last visit, have any diagnostic HIV tests been performed?

No HIV test has been done

A DNA PCR test was done and was:  Positive  Negative

Date:  /  /

A RNA PCR test was done and was:  Positive  Negative

Date:  /  /

If positive, the number of copies was: \_\_\_\_\_

An HIV antibody test was done and was:  Positive  Negative

Date:  /  /

11. If HIV-infected, what is the patient's most recent CD4 count?

/mm<sup>3</sup>

%

Date specimen collected

/  /

12. Since the last visit, has the patient had any other significant clinical or laboratory findings that will change his/her medical management? If so, please detail here:

13. If not on OI prophylaxis, indicate eligibility for OI prophylaxis as of this visit:

Not yet determined/ awaiting other information

Ineligible

Eligible →

Newly eligible for prophylaxis by CD4 count → CD4 count =  CD4%:

CD4 specimen date:  /  /

Newly eligible for ART by WHO Stage → WHO Stage =

Previously eligible for prophylaxis (specify):

14. If not on antiretroviral treatment (ART), indicate eligibility for ART as of this visit:

Not yet determined/ awaiting other information

Ineligible

Eligible →

Newly eligible for ART by CD4 count → CD4 count =      CD4%:

CD4 specimen date:   /   /

Newly eligible for ART by WHO Stage → WHO Stage =

Previously eligible for ART (specify): \_\_\_\_\_

Questions 15-17 are intended for patients taking ART. If the patient is not taking ART, skip to question 18.

15. At this visit, who is providing information regarding the patient's adherence to ARV medications?

Fill in 'O' for all that apply:

Mother  Father  Sibling  Patient  Other (specify):

16. If the patient is taking ARVs, during the last 7 days, how many pills did the patient take? (Fill in only one):

None of her/his pills  Very few of her/his pills  About half of her/his pills

Most of her/his pills  All of her/his pills every day → If all taken, skip to Question 18

17. If the patient missed any pills in the last seven days, what reason(s) did s/he provide? (Fill in all that apply):

Forgot  Clinic ran out of medication  Patient ran out of pills  
 Felt too ill  Lost her/his medication  Other reason: \_\_\_\_\_  
 Side effects  Disclosure or privacy issues

18. List all medications being started, stopped, or continued:

Medication	Recommendation			Reasons for Stopping Meds*	Dose and Comments
	Start	Stop	Continue		
Cotrimoxazole	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Dapsone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Zidovudine (AZT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Lamivudine (3TC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Stavudine (D4T)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Didanosine (DDI)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Abacavir (ABC)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Nevirapine (NVP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Efavirenz (EFV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Nelfinavir (NFV)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Lopinavir/ritonavir (LPV/r)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Tenofovir (TDF)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Isoniazid (INH):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Rifampin (RIF):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Ethambutol (ETH):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Pyrazinamide (PZA):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Streptomycin (STREP):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other (specify):	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

\* Reasons for Discontinuation:

1 = Side Effect / Toxicity / Drug interaction    3 = Patient non-adherence    5 = pMTCT prophylaxis complete    7 = Other, specify  
 2 = Disruption in Drug Supply / Stock out    4 = Treatment failure    6 = Patient refused

19. Has the patient received any immunizations since his/her last visit?  Yes  No

*If yes, fill in 'o' for all that apply; leave total number of doses column blank if unknown.*

Vaccine	Yes	Total number of doses received since last visit	Vaccine	Yes	Total number of doses since last visit
BCG	<input type="radio"/>		Measles	<input type="radio"/>	
HBV	<input type="radio"/>		Yellow Fever	<input type="radio"/>	
DPT	<input type="radio"/>		Other 1 (specify):	<input type="radio"/>	
OPV	<input type="radio"/>		Other 2 (specify):	<input type="radio"/>	

20. Patient Plan

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21. What tests will be ordered for the patient? *Fill in 'o' for all that apply:*

- None
- Complete Blood Count
- CD4 Count Assay
- ALT (Alanine Aminotransferase)
- AST (Aspartate Aminotransferase)
- Creatinine
- Electrolytes
- Sputum for AFB
- Tuberculin skin test (TST using PPD)
- HIV DNA PCR
- HIV RNA PCR
- HIV antibody test
- Radiology test (specify): \_\_\_\_\_

22. What referrals will be made for the patient? *Fill in 'o' for all that apply:*

- None
- Nutritional support
- Psychosocial counseling
- In-patient care / Hospitalization
- TB treatment / DOT program
- Adherence counseling
- Mental health services
- Social support services
- Other referral (specify): \_\_\_\_\_

23. When is the patient's next appointment?

- 1 week
- 1 month
- 2 months
- 3 months
- 6 months
- Other (specify): \_\_\_\_\_

Appointment Date: } →  /  /   
day    month    year

Form Completed By: \_\_\_\_\_ Provider Initials: