## ANNEX 2. PATIENT REGISTRY FORM

### Patient details
- ID/patient card no.: [ ]
- Date of first visit: [ ]
- Date of exposure: [ ]
- Time of exposure (range): [ ]–[ ]
- Hours between exposure and post-exposure prophylaxis: [ ]
- Exposure type:
  - [ ] Occupational
  - [ ] Non-occupational
  - [ ] Receptive vaginal
  - [ ] Receptive anal
  - [ ] Receptive oral with ejaculation
  - [ ] Shars injury (instrument):
  - [ ] Other (such as mucous membrane splash)
- HIV status of source person:
  - [ ] Known positive
  - [ ] Unknown
- Anti-retroviral therapy history of source person:
  - [ ] None or unknown
  - [ ] Yes (describe)
- Date of last HIV test: [ ]
- Result of last HIV test:
  - [ ] Positive
  - [ ] Negative
- Other exposure incidents in past six months (number and type):

### Health history
- Pertinent past health history:
- Alcohol use:
- Drug allergies:
  - [ ] None known
  - [ ] Yes
  - If yes, specify:
  - Current medicine taken:

* Please note that, if the test is positive or if there are any clinical symptoms of HIV infection at the preliminary visit, post-exposure prophylaxis should not be proposed and the patient should be referred to a treatment centre.

### Age (years):

### Sex: [ ] F  [ ] M

### Symptoms (if status unknown)*
- Signs of possible acute HIV infection (include duration):
- Evaluated or referred for evaluation: [ ] Yes  [ ] No
- Clinical assessment*
  - Thrush:  [ ] Yes  [ ] No
  - Lymphadenopathy:  [ ] Yes  [ ] No
  - Kaposi sarcoma:  [ ] Yes  [ ] No
  - Other:

### Risk assessment and care plan
- HIV exposure confirmed and seeking post-exposure prophylaxis
- Post-exposure prophylaxis medicine:
  - [ ] Tenofovir + Lamivudine oral tablets once daily and Lopinavir/ritonavir tablets twice a day
  - or [ ] Other
- Reviewed with patient: drug information, adverse events, emergency phone numbers, medicine adherence and use of alcohol
- Follow-up appointment made
- Sexually transmitted infection treatment
- Emergency contraception

### Laboratory tests ordered:
- HIV test
- HIV positive (refer for counselling and evaluation)
- HIV negative
- Pregnancy test result:
  - [ ] Positive
  - [ ] Negative
  - [ ] Not available
  - Other (specify):
- Referrals:
- Notes:
- Signature: ___________________ Date: ___________________