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:

Name_________________________________

Exposure type:

☐ Occupational ☐ Non-occupational

☐ Receptive vaginal ☐ Receptive anal

☐ Receptive oral with ejaculation

☐ Sharps 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):

____

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

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.

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: ______________