

## ART REGISTER:

Personal Details **and** ART  
 Start  
 Serial No  
 HIV Care No  
 Eligibility No/ Approval **Date**  
 ART Start **Date**  
 Onset **of** TB treatment **Date**  
 First Name  
 Surname  
 D.O.B  
 Sex  
 Address & Phone No  
 Entry Point  
 Status **on** Commencement **of** ART:  
 Weight (kg)  
 HB  
 BMI  
 Child: Height (cm)  
 HIV Type  
 KPS  
 CD4 **Count**

1st-line regimen:  
 Original regimen  
 Substitutions            1st: Reason/**date**   2nd: Reason/**date**

2nd-line regimen:  
 Original regimen  
 Substitutions            1st: Reason/**date**   2nd: Reason/**date**

Variable	Comment
Serial No	The sequence <b>in</b> which clients
were entered <b>into</b> the register	
Patient Clinic No/TB Registration <b>Number</b>	This <b>is</b> the patient's
sequential Clinic <b>number/and or</b> TB registration <b>number</b>	Enter eligibility <b>number in</b>
Eligibility No/Approval <b>Date</b>	
<b>upper row and date of</b> approval <b>in lower row</b>	Enter the <b>date</b> the patient
ART Start <b>Date and/or</b> Onset <b>of</b> TB treatment	received the <b>first</b> dose <b>of</b> ART <b>and/or</b> the start <b>date of</b>
First Name/Surname	Enter the patient's <b>first</b>
name <b>in</b> the <b>upper row and</b> the surname <b>in</b> the <b>lower row</b>	
Age	This <b>is</b> the patient's age <b>in</b>
years. If patient <b>is</b> an infant specify age <b>in</b> months	
Sex	Enter M <b>for</b> male clients <b>and</b>
F <b>for</b> female patients	
Address (Phone No.) Location	This <b>is</b> patient's residential
address <b>and</b> contact telephone <b>number and</b> also Describe <b>in</b> detail how best the patient	can be trace
Weight	Enter the patient's <b>current</b>
<b>weight</b>	
<b>Child Height (cm)</b>	Enter patient's height if he/
she <b>is</b> a child	

HIV type	Enter the patient's HIV serotype (e.g. HIV -1, etc)
KPS	Karnofsky score is the staging in HIV disease progression and is indicated in figures e.g. 0 - 100
CD4 Count	Enter CD4 count at registration
Original regimen	Indicate original 1st line regimen
Substitutions 1st: Reason/date/2nd: Reason/date	Indicate reason for substituting original 1st line regimen with another 1st line regimen. Give reason (use code) and date for first substitution in upper row and reason (use code) and date for second substitution in lower row
Original regimen	Indicate original 2nd line regimen in upper row and reason for the 2nd line regimen in the lower row
Substitutions 1st: Reason/date/2nd: Reason/date	Indicate reason for substituting original 2nd line regimen with another 2nd line regimen. Give reason (use code) and date for first substitution in upper row and reason (use code) and date for second substitution in lower row
Drugs	Enter appropriate code for ART each month in upper row and appropriate code for OI prophylaxis and/or treatment in lower row
Comment	Additional information or comments may be entered here

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Reasons for change of regimen

1. Toxicity
2. Pregnancy
3. Risk of pregnancy
4. New TB diagnosed
5. New drug available
6. Drug out of stock
7. Other

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Follow-up status at the end of each month

On treatment (current regime abbreviation)

DEAD

STOPped ART (but continued other care)

LOST (not seen in the month of reporting)

RESTART (resuming ART after interruption)

T0 (transferred out, indicate to where)

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"Entry point into HIV care & treatment

1. TB

- 2. Sex worker outreach
- 3. Self-referred via VCT
- 4. Antenatal/PMTCT
- 5. Medical outpatient
- 6. Under 5 clinic
- 7. STI clinic
- 8. Inpatient ward
- 9. CBO-referred via VCT
- 10. Private doctor
- "

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If follow-up status is "STOP", then add reasons:

- 1. Toxicity/side effects
- 2. Pregnancy
- 3. Treatment failure
- 4. Poor adherence
- 5. Illness/hospitalization
- 6. Drugs out of stock
- 7. Planned interruption
- 8. Patient decision
- 9. Other

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Type of support:

- ARV
- TB Screening
- Home-based care
- OI Treatment
- OI Prophylaxis
- Nutrition
- CD4
- Viral Load (Value)

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Type of opportunistic infection treated :

- 1. TB
- 2. Other
- Respiratory
- 3. STI
- 4. Oral thrush
- 5. Other Alimentary
- 6. Skin & appendages
- 7. Urinary
- 8. Central nervous system
- 9. Eye
- 10. Other

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Follow-up status at the end of each month :  
P(1, 2 or 3) (received prophylaxis for duration in months)  
N (not on prophylaxis)  
DEAD  
STOPped prophylaxis (but continued other care)  
LOST (not seen as scheduled in the month of reporting)  
RESTART (resuming prophylaxis after interruption)  
TO (transferred out, indicate to where), TI(transferred in, indicate

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INFANT REGISTER:

Serial No  
Date  
Mother's PMTCT No  
Mother's First Name / Surname  
D.O.B  
Address  
Phone No  
Location  
Mother's HIV type  
FH  
GA  
EDD  
ARV prophylaxis/ART regime / Date started  
Delivery Date & Time  
Place of delivery  
Pregnancy outcome  
Child's First Name Surname  
Sex  
Weight at birth  
ARV prophylaxis regime Date & time given to infant  
Cotrim Start date  
Feeding method  
Mother offered Exclusive BF for 6 months Max.  
HIV tested result at 6 weeks with PCR/EID  
HIV antibody test at 18 months  
Referral  
Comments  
Nutrition & Opportunistic infections

Variable	Comment
Serial No entered into the register	The sequence in which clients were entered into the register
Date register	This is the date of entry into this register
PMTCT No number	This is the client's sequential PMTCT number
First name /Surname entered in the upper row and the surname in the lower row	The client's first name should be entered in the upper row and the surname in the lower row
Age	This is the client's age in years
Address (Phone No.) residential address. The contact telephone should be entered if available	This is the antenatal client's residential address. The contact telephone should be entered if available
Location how the client can be trace	Describe <b>to</b> the best <b>of</b> your ability how the client can be trace
HIV type S2 <b>or</b> S3	Indicates mother's HIV serotype , S1, S2 <b>or</b> S3
FH register	Fundal height at the time <b>of</b> entry <b>on</b> register
GA antenatal client at the time <b>of</b> entry <b>on</b> register	This <b>is</b> the gestational age <b>of</b> the antenatal client at the time <b>of</b> entry <b>on</b> register
EDD	This <b>is</b> the expected <b>date of</b> delivery
ARV prophylaxis regime <b>Date</b> issued <b>to</b> mother the antenatal client (e.g. nevirapine, AZT etc). The <b>date on</b> which it was given <b>to</b> the <b>client</b> should be entered <b>in</b> the <b>row</b> below	This <b>is</b> the name <b>of</b> the ARV given <b>to</b> the antenatal client (e.g. nevirapine, AZT etc). The <b>date on</b> which it was given <b>to</b> the <b>client</b> should be entered <b>in</b> the <b>row</b> below
<b>Date</b> administered client actually ingested the drug <b>for</b> prophylaxis	This <b>is</b> the <b>date</b> that the antenatal client actually ingested the drug <b>for</b> prophylaxis
Delivery <b>date</b> & time <b>date of</b> delivery should be entered <b>in</b> the <b>row</b> above <b>and</b> the time <b>of</b> delivery <b>in</b> the <b>row</b> below	This <b>is</b> the <b>date</b> do delivery. The <b>date of</b> delivery should be entered <b>in</b> the <b>row</b> above <b>and</b> the time <b>of</b> delivery <b>in</b> the <b>row</b> below.
Place <b>of</b> delivery (e.g, hospital, health centre, home, TBA). If health facility, enter the name <b>of</b> the health facility <b>in</b> the <b>row</b> below	Indicate <b>where</b> the client gave birth (e.g, hospital, health centre, home, TBA). If health facility, enter the name <b>of</b> the health facility <b>in</b> the <b>row</b> below
Child's First Name_Surname <b>in</b> upper row and surname <b>in</b> lower row	This <b>is</b> the child's name (First Name in upper row and surname in lower row)
Sex	Enter M <b>for</b> male <b>and</b> F <b>for</b> female
Weight at Birth	Enter Child's birth weight
ARV prophylaxis regime <b>Date</b> issued to Child child in the upper row and the date of administration in the lower row	Indicate the ARV drug given to the child in the upper row and the date of administration in the lower row
Feeding option	Enter the chosen feeding method
Co-trim start date was started	Enter the date Co-trim prophylaxis was started
Age Weaned beyond 6 months	Indicate the age weaning
Mothers' offered <b>Exclusive</b> BF <b>for</b> 6 months	Indicate whether the <b>exclusive</b>
Breastfeeding was opted <b>for</b> 6 months	
HIV tested positive at 6 weeks <b>with</b> PCR upper row <b>and</b> date <b>in</b> the lower row	Indicate the HIV sero type <b>in</b> the upper row <b>and</b> date <b>in</b> the lower row
Comments may be entered here	Additional information <b>or</b> comments may be entered here

Nutrition & Opportunistic infections:

Replacement feed  
Nutritional support

Co-trim  
 ARV Mother  
 ART Mother  
 CD4  
 Viral Load (Value)

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CARE SUPPORT REGISTER:

Serial No:  
 VCT/PMTCT No:  
 Date of enrolment:  
 HIV Care No:  
 Name:  
 D.O.B:  
 Sex:  
 Address :  
 Phone No:  
 Location:  
 Entry Point:  
 Status on entry to  
 Care :  
 Type of Support:  
 Weight (kg)  
 Height (cm)  
 HB  
 HIV Type  
 BMI  
 KPS  
 CD4 Count  
 Eligibility Number  
 ART Start date  
 Type of Support

**Comment**

The sequence in which clients were entered into the register  
 This is the date of enrolment in HIV Care. It should be sequential  
 This is the patient's sequential Clinic number  
 This is the patient's first name  
 This is the patient's surname  
 This is the patient's age in years. If patient is an infant specify age in months  
 Enter M for male clients and F for female patients  
 This is patient's residential address and contact telephone number  
 Enter the patient's current weight  
 Enter patient's height if he/she is a child  
 Enter the patient's HIV serotype (e.g. HIV -1, etc)  
 Karnofsky score is the staging in HIV disease progression and is indicated in figures  
 e.g. 0 - 100  
 Enter CD4 count at registration  
 Enter eligibility number in upper row and date of first ART dose in lower row  
 Mark in the month that the PLHIV was provided with nutritional support, transport  
 fares; home based care; educational support (if a child); other support; OI

treatment; OI prophylaxis

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Types of Supports:

TB Screening  
Nutritional  
Home-based care  
OI Treatment  
OI Prophylaxis  
CD4  
Viral Load

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If support was not provided enter code  
DEAD  
STOPped receiving support (but continued other care)  
LOST (not seen in the month of reporting)  
RESTART (resuming support after interruption)  
TO (transferred out, indicate to where)

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Type of opportunistic infection treated :  
1.  
TB  
2. Other  
Respiratory  
3. STI  
4. Oral thrush  
5. Gastrointestinal  
6. Skin & appendages  
7. Urinary  
8. Central nervous system  
9. Eye  
10. Other

=====  
Follow-up status at the end of each  
month  
P(1, 2 or 3) (received prophylaxis for duration in  
months)

N (not on prophylaxis)  
ART (on ART, please transfer to ART register & continue follow-up there)  
DEAD  
STOPped prophylaxis (but continued other care)  
LOST (not seen as scheduled in the month of reporting)  
RESTART (resuming prophylaxis after interruption)  
TO (transferred out, indicate to where)

=====

Entry point into HIV care & treatment

1. TB
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9. CBO\_referral via VCT
10. Private Doctor