

NAME: _____ SURNAME: _____ FILE NR: _____ DOB: ____/____/____

HPRS NR: _____



GAUTENG PROVINCE

HEALTH
REPUBLIC OF SOUTH AFRICA



**City of
Ekurhuleni**

**DEPARTMENT OF HEALTH
ADULT CHRONIC DISEASE CLINICAL STATIONERY (>18Y)**

FACILITY NAME: _____

PATIENT GENDER: _____ PATIENT AGE: _____

ID/PASSPORT/OTHER IDENTIFICATION: _____

PATIENT ADDRESS: _____

CONTACT NUMBER/S: _____

KNOWN ALLERGIES: _____

NEXT OF KIN:

NAME and SURNAME: _____

CONTACT NUMBER/S: _____

RELATIONSHIP: _____

☐ NEW CHRONIC PATIENT - DATE STARTED AT CLINIC: _____

☐ TRANSFER-IN PATIENT - DATE TRANSFERRED IN: _____

☐ KNOWN CHRONIC PATIENT - DATE STARTED WITH NEW STATIONERY: _____

PATIENT BOOKLET NUMBER: _____

NAME: _____

SURNAME: _____

FILE NR: _____

DOB: ____/____/____

HPRS NR: _____

NCD AND CHRONIC DISEASE INFORMATION/ REFERENCE PAGE

Cardiovascular Disease Risk Assessment (EDL)

Framingham Risk Score (cholesterol-based)

Calculation of risk of developing cardiovascular events over 10 years

To derive the absolute risk as a percentage of patients who will have a cardiovascular event (i.e., Death, myocardial infarction or stroke) over 10 years, add the points for each risk category (Section A).

The risk associated with the total points is then derived from Section B.

SECTION A

Age (years)	MEN	WOMEN
30-34	0	0
35-39	2	2
40-44	5	4
45-49	6	5
50-54	8	7
55-59	10	8
60-64	11	9
65-69	12	10
70-74	14	11
75-79	15	12
Total cholesterol (mmol/L)	MEN	WOMEN
<4.1	0	0
4.1-5.19	1	1
5.2-6.19	2	3
6.2-7.2	3	4
>7.2	4	5
HDL cholesterol (mmol/L)	MEN	WOMEN
>1.5	-2	-2
1.3-1.49	-1	-1
1.2-1.29	0	0
0.9-1.19	1	1
<0.9	2	2
Smoking	MEN	WOMEN
Smoking	4	3
Diabetic*	3	4

*Type 2 diabetics > 40 years of age qualify for statin therapy irrespective of risk score.

Systolic BP (mmHg)	MEN		WOMEN	
	Un treated	Treated	Un treated	Treated
<120	-2	0	-3	-1
120-129	0	2	0	2
130-139	1	3	1	3
140-149	2	4	2	5
150-159	2	4	4	6
≥160	3	5	5	7

MENTAL HEALTH FOLLOW UP ASSESSMENT FORM – QUESTIONS TO ASK

1	CURRENT COMPLAINTS	Identify problem, duration, home remedy or treatment used
2	CURRENT TREATMENT	Knowledge of treatment used & compliance to treatment
3	DRUG SIDE EFFECTS	Feeling stiff, epigastric pain, nauseous, dry mouth
4	SLEEPING AND EATING	Sleep pattern or difficulty falling asleep and appetite
5	PSYCHOSOCIAL STRESS FACTORS	Check common stressors like living conditions, finance, family relations, school, work, age, peer group influence, marital status.
6	INSIGHT	Insight to condition
7	DEPRESSED MOOD	Feeling sad or happy, wants to kill himself, hopeless, worthless, lost interest in life
8	PSYCHOTIC SYMPTOMS	Hearing voices, hallucinating, sensation of things crawling on body, violent/ aggressive behaviour
9	ANXIETY SYMPTOMS	Nervousness, palpitations, PTSD
10	OTHER	

MENTAL STATUS EXAMINATION

11	BEHAVIOUR, SELF-CARE, MOOD, SUICIDE ATTEMPT, PSYCHOTIC SYMPTOMS	IMPORTANT - must be observed when patient is in front of the examiner. Abnormal behaviour, grooming, mood & psychosis Suicide attempt or thought of suicide
12	TREATMENT PLAN	Investigations, booking an appointment with the Dr, review date, referral to MDT or Hospital, date of next visit.
13	SPECIAL INVESTIGATIONS	- Screening for cannabis sent urine specimen six monthly. - Take therapeutic blood levels six monthly. - Take lithium blood levels quarterly for FBC, Urea, and Creatinine clearance. - Take Clozapine blood levels monthly for WCC and diff. - Sputum GxP with productive cough - ECG if complains of chest pain

SECTION B (Total points and percentage risk table for Calculating Cardiovascular Risk score)

MEN	10-YEAR RISK %	WOMEN	10-YEAR RISK %	MEN	10-YEAR RISK %	WOMEN	10-YEAR RISK %
≤ -3	< 1	≤ -2	< 1	8	6.7	9	5.3
-2	1.1	-1	1.0	9	7.9	10	6.3
-1	1.4	0	1.2	10	9.4	11	7.3
0	1.6	1	1.5	11	11.2	12	8.6
1	1.9	2	1.7	12	13.2	13	10.0
2	2.3	3	2.0	13	15.6	14	11.7
3	2.8	4	2.4	14	18.4	15	13.7
4	3.3	5	2.8	15	21.6	16	15.9
5	3.9	6	3.3	16	25.3	17	18.5
6	4.7	7	3.9	17	29.4	18	21.5
7	5.6	8	4.5	≥ 18	>30	19	24.8

PATIENT CLINICAL CHRONIC DISEASE OVERVIEW: SUMMARY OF CHRONIC CONDITIONS, COMORBIDITIES, COMPLICATIONS AND RISK FACTORS (Please update as diseases, complications, problems and risk factors develop or change)									
DIAGNOSTIC CONDITION / COMORBIDITIES: Tick appropriate condition & Insert date (year and month if available) of disease diagnosed.									
CONDITION	✓	DATE DIAGNOSED	CONDITION	✓	DATE DIAGNOSED	CONDITION	✓	DATE DIAGNOSED	
HIV			Diabetes: Type 1			Cancer			
			Diabetes: Type 2			Type:			
ART (Start Date)			Hypertension			Stroke			
TB			Ischaemic Heart Disease			Heart Failure			
Any Mental Illness:			Epilepsy			COPD			
Any Renal Disease:			Asthma			Dyslipidemia			
Other:			Other:			Other:			
COMPLICATIONS/PROBLEMS: Tick appropriate condition/complication and insert date (year and month if available) Please refer appropriately if complication or problem diagnosed (whenever a condition or complication is diagnosed)									
CONDITION	✓	DATE DIAGNOSED	CONDITION	✓	DATE DIAGNOSED	CONDITION	✓	DATE DIAGNOSED	
Malignant HPT			Stroke			Persistent Infections/ Ulcers/ Gangrene			
Urine Protein 1+ or more			Transient Ischemic Attack (TIA)			Eyesight Problems/ Advanced Retinopathy			
Urine Haematuria 1+ or more			Heart Failure			Respiratory Issues - Require Home Oxygen Therapy			
High Creatinine (M >133 umol/l, F >124 umol/l)			Left Ventricular Hypertrophy (ECG)			Pregnant or complications from previous pregnancies			
Low eGFR <60ml/min/1.73m2			Peripheral Artery Disease			Other:			
Any Renal Disease:			Other:			Other:			
CONDITION	✓	DATE DIAGNOSED			CONDITION	✓	DATE DIAGNOSED		
Uncontrolled Hypertension: BP uncontrolled > 3 visits					Uncontrolled Diabetes: DM uncontrolled > 3 visits				
Uncontrolled Epilepsy: Any Seizure in last 6 months					Uncontrolled Asthma: Use of Salbutamol more than 2-3 times/week				
Mental Health: Persistent symptoms on treatment					Other (e.g., Treatment Interruption)				
PAST AND RELEVANT SURGICAL HISTORY									
RISK FACTORS	Baseline		Update (If change noted)		Update (If change noted)		Cardiovascular Risk Assessment Score - EDL Guidelines		
Circle where appropriate	Date:		Date:		Date:		Date Scored for CVR:	Points	
Family History: DM / HPT/ Chol/ Asthma/ Heart Disease at early age (M-55y; F-65y) or Mental Illness							Age		
Tobacco: Type: Cigarettes/ Snuff/ Pipe / How Many per day							Total Cholesterol		
Alcohol: How Often: Daily/ Weekly/ Monthly/ Occasionally/ How Many							HDL Cholesterol		
Substance Abuse: Type/ How Often							Smoker		
Exercise: Type/ How Often							Known DM		
Diet: Type/ How Often							Systolic Blood Pressure (treated/ untreated)		
Waist Circumference: M ≥ 94cm F ≥ 80cm							TOTAL CARDIOVASCULAR RISK POINTS (EDL)		%
							Management Based on CVS Risk Score:		
							☐ <10% - Lifestyle modification & RA every 5 years ☐ 10-20% - Lifestyle modification & RA annually ☐ >20% - Lifestyle modification & start statin Rx		

SIDE ROOM MEASUREMENTS and LABORATORY INVESTIGATION PAGE *(Please complete at every visit & enter visit date)*

MEASUREMENTS AND SIDE ROOM TESTS (VITALS)											
Height: _____ cm [date measured: _____]				Waist Circumference: _____ cm [date measured: _____]							
VISIT DATE											
Weight (kg)											
Waist Circumference (cm)											
BMI kg/m ²											
Temperature											
Pulse											
Respiratory Rate											
1 st BP – Systolic / Diastolic											
2 nd BP – Systolic / Diastolic											
HGT-Glucose (Random)											
HGT-Glucose (Fasting)											
Haemoglobin											
Urine Dipstix											
Pregnancy Test											
HIV Rapid Test											
Peak Flow Reading											
Inhaler Technique Check											
Other											

DATE BLOODS TAKEN:													
LABORATORY INVESTIGATIONS			✓ RE SULT		✓ RE SULT		✓ RE SULT		✓ RE SULT		✓ RE SULT		
HIV	CD4 (CD4%)	BARCODE			BARCODE			BARCODE			BARCODE		
	Urine LAM												
	Viral Load (VL)												
	Cryptococcus Antigen												
TB	GeneXpert												
LFT	ALT												
DM	Blood HbA1c												
	Blood Glucose												
LIPIDS	Total Cholesterol												
	LDL												
	Triglyceride												
U&E	Potassium (K)												
	Urea												
	Creatinine												
	eGFR												
URINE	Creatinine Clearance												
	Albumin/ Creatinine Ratio (ACR)												
FBC	Hb / PLT												
	WCC & Diff Count												
CAN CER	PSA												
	Pap Smear												
MEN TAL	5 Drug Panel Test/ Urine Cannabis												
	Epilim/Lithium/Valproate/ Clozapine Level												
OTHE R	TSH												
	RPR												
	Hep B Antigen												
	Other												

SIDE ROOM MEASUREMENTS and LABORATORY INVESTIGATION PAGE *(Please complete at every visit & enter visit date)*

[illegible]

Height: _____ cm [date measured: _____] **Waist Circumference:** _____ cm [date measured: _____]

[illegible][illegible]

ADDITIONAL INVESTIGATIONS and REPRODUCTIVE HEALTH/ PREGNANCY RECORD			
INVESTIGATIONS (Additional Investigations including X-Ray, ECG, Ultrasound, Sputum, Culture, etc.)			
XRAY	Date:	Date:	Date:
ECG	Date:	Date:	Date:
OTHER:	Date:	Date:	Date:
OTHER:	Date:	Date:	Date:
OTHER:	Date:	Date:	Date:

REPRODUCTIVE HEALTH:		Date Assessment Made: ____ / ____ / ____	
Complete relevant sections depending on gender			
Current Contraceptives: ☐ None ☐ Condoms ☐ Injection ☐ Pill ☐ IUD ☐ Subdermal implants ☐ Other:		Last Pap Smear Result:	Date:
Previous STI Diagnosis:	Date	Diagnosis	Treatment Completed
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
		RPR (Test Date)	Result
			Treatment Completed
			☐ Y ☐ N
PREGNANCY RECORD			
Gravida:		Parity:	
		Miscarriages/Abortions/TOP:	
#	Child DOB	Gender	Planned/ Unplanned Pregnancy
			Born Alive/ Stillbirth/ Other
			Complications during Pregnancy
			If mother HIV positive was baby given prophylaxis?
			Contraception Used Post Delivery
1			☐ Y ☐ N ☐ N/A
2			☐ Y ☐ N ☐ N/A
3			☐ Y ☐ N ☐ N/A
4			☐ Y ☐ N ☐ N/A
5			☐ Y ☐ N ☐ N/A

SOCIAL STATUS and NEED for ASSISTANCE:								Date Assessment Made: ____/____/____							
Housing: ☐ Informal dwelling ☐ Formal house ☐ Hostel ☐ Other - Specify: _____								No. Rooms: _____				Refrigerator: ☐ Yes ☐ No			
No. of Adults in House: _____ No. of Children in House (<18Y): _____ ☐ Married ☐ Living with Partner ☐ Single ☐ Widow/er								Disclosure: Has the patient disclosed his/her chronic condition to anybody else? ☐ Yes ☐ No							
Source of Income: ☐ Employed ☐ Grants ☐ Pension ☐ Friend & Family ☐ Other - Specify: _____								Qualifies for Grant: ☐ Yes ☐ No ☐ DG ☐ Child ☐ Other: _____				Receiving Grant: ☐ Yes ☐ No ☐ Applied			
☐ Contact Tracing (TB) OR ☐ Index Testing (HIV): No. of Individuals to Consider for Tracing No. of Adults: _____ No. of Children < 5Y: _____ No. of Children 5-15Y: _____								Other: _____							
Age and HIV Status of Children (If applicable)															
Own Children	Age							Other Children in Household							
HIV Status	- / + / unknown							Age							
In Household	Y / N							HIV Status - /+ / Unknown							

REFERRAL SUMMARY (All Referrals - Dietician; Eyecare services; Podiatrist; Mental Health; Adherence Counselling; Social Worker; Other Multidisciplinary Team Members; Hospital)				
	Referred To	Date Referred	Date Seen	Feedback
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

HIV FIRST VISIT AT CLINIC - CLINICAL ASSESSMENT

Date Assessment Made: _____

HAART PRIOR TO START DATE: ☐ None ☐ PMTCT ☐ HAART ☐ PrEP

Details:

Presents from: ☐ TB clinic ☐ PMTCT ☐ PICT ☐ Index testing; ☐ Routine offer ☐ GP ☐ Other ART Clinic ☐ Primary Care Clinic ☐ In-patient
☐ DCS ☐ Work ☐ Other (explain)

WHO CLINICAL STAGING

CLINICAL FEATURES			Date:	CLINICAL FEATURES			Date:
WHO Stage 1	Asymptomatic	Persistent Generalized Lymphadenopathy		WHO Stage 4 - Advanced HIV Disease	Herpes Simplex Virus Lesion > 1 month		
		Other:			Oesophageal candidiasis		
WHO Stage 2	Moderate Disease	Weight loss < 10% body weight			Pneumocystis jirovecii (PCP)		
		Minor Mucocutaneous conditions			Kaposi's sarcoma		
		Recurrent URTI			HIV wasting syndrome		
		Uncomplicated Herpes Zoster			HIV encephalopathy		
		Other:			Recurrent pneumonia		
WHO Stage 3	Advanced HIV Disease	Weight loss > 10% body weight			Cytomegalovirus		
		Diarrhoea > 1 month			Isosporiasis / Cryptosporidiosis		
		Oral Candidiasis			Bedridden > 50%/ day for most of the last month		
		Severe bacterial infections including Pneumonia			Cryptococcal meningitis		
		Oral hairy leukoplakia			Cervical cancer		
		Prolonged fever			Lymphoma		
		Bedridden <50%/day for most of the last month			Clients with MDR/XDR -TB irrespective of CD4 count or *Clients with CD4 >350cells/mm3 who have TB/HIV or who are pregnant		
		Pulmonary TB (current or in the last year)			CD4 Result		
		Other					

REPRODUCTIVE HEALTH – Refer to Page 5 for the Reproductive health history, ask these additional questions on current situation

Pregnant: ☐ Y ☐ N	Trimester: ☐ 1 ☐ 2 ☐ 3	Gravida:	Parity:	Pap smear result:	Date:
Contraceptives: ☐ None ☐ Condoms ☐ Injection ☐ Pill ☐ Other:					
Signs and Symptoms of STI today?	1.Urethral Discharge/Dysuria ☐ Y ☐ N	2.Vaginal Discharge ☐ Y ☐ N	3.Genital Ulcers ☐ Y ☐ N	4.Genital Warts ☐ Y ☐ N	5. Lower Abdominal Pain ☐ Y ☐ N
				RPR (date)	Result:
					Treatment completed: ☐ Y ☐ N

TUBERCULOSIS SCREEN / WORK-UP

Ever had TB before? ☐ Y ☐ N	IF YES	Year	Extra-Pulmonary or Pulmonary TB	Treatment Outcomes
Current TB? ☐ Y ☐ N	Extra-Pulmonary or Pulmonary TB:			Date Commenced Treatment:
TB Symptoms today	Cough of any duration ☐ Y ☐ N	Weight Loss ☐ Y ☐ N	Fever ☐ Y ☐ N	Night Sweats ☐ Y ☐ N
				Haemoptysis ☐ Y ☐ N
				Fatigue ☐ Y ☐ N
GeneXpert: ☐ Y ☐ N	Date	Culture/ Sensitivity	Date	Clinical Indication of TB ☐ Y ☐ N
Chest Xray: ☐ Y ☐ N	Result		Result	

NUTRITIONAL SCREEN Height (cm): _____ Weight (kg): _____ BMI (kg/m²): _____

PLAN: (VIP: Identify patients with Advanced HIV Disease and offer AHD Package of Interventions)

CD4 < 200 ☐ Y ☐ N	Co-trimoxazole ☐	SCREENED FOR:		QUALIFIES FOR:		STARTED ON:	
Any CD4 AND WHO Stage 3 or 4 ☐ Y ☐ N	Fluconazole ☐	IPT/3HP ☐ Y ☐ N	Date:	ITP/3HP ☐ Y ☐ N	Date:	ITP/3HP ☐ Y ☐ N	Date:
Pregnant ☐ Y ☐ N	TB ☐ Y ☐ N	Cotrimoxazole ☐ Y ☐ N	Date:	Cotrimoxazole ☐ Y ☐ N	Date:	Cotrimoxazole ☐ Y ☐ N	Date:
Seriously Ill / Admission ☐ Y ☐ N	Other:	Fluconazole ☐ Y ☐ N	Date:	Fluconazole ☐ Y ☐ N	Date:	Started Fluconazole ☐ Y ☐ N	Date:

CLINICAL EVALUATIONS FOR HAART OR TO RE-START HAART

HISTORY INCLUDING PRIOR HAART HISTORY (Prior HAART history, detail period when taken, Rx changes, reason/s they stopped Tx)

Test	Date	Results
ALT		
Hb-Heamoglobin		
CD4		
Creatinine Clearance		

MENTAL HEALTH FIRST VISIT				Date Assessment Made: ____/____/____			
Accompanying person/ relative:				Contact details if different to next of kin on front page:			
Relationship Status ☐ M ☐ Stable Rel ☐ W ☐ D ☐ Single				Social Support ☐ Family ☐ Friends ☐ Church ☐ Work ☐ None ☐ Other			
Referral Letter: ☐ Yes ☐ No Reason for referral: ☐ New assessment ☐ Continuation of psychiatric treatment ☐ Other:				Referral Source ☐ Self ☐ Family ☐ PHC ☐ Hospital Psych Unit ☐ Hospital Medical Unit ☐ Prison or Court ☐ Social Welfare ☐ Other			
MENTAL HEALTH HISTORY: Tick PAT (patient) box if patients mentioned the history and FAM (Family) box if the family/relative mentioned the history. If the symptoms don't apply related to the different sections tick the None or Not applicable box for that section of the history.							
Main reason/concern from patient or family for seeking assistance NOW:							
MOOD SYMPTOMS:				☐ None ☐ N/A		Space to make additional notes	
PAT	FAM	Problem with:	PAT	FAM	Problem with:		
☐	☐	Depressed	☐	☐	Interest in activities		
☐	☐	Elevated mood	☐	☐	Social participation		
☐	☐	Sleep pattern	☐	☐	Self-harm		
☐	☐	Eating pattern	☐	☐	Suicidal ideas		
ANXIETY SYMPTOMS:				☐ None ☐ N/A			
PAT	FAM	Problem with:	PAT	FAM	Problem with:		
☐	☐	Feeling of anxiety	☐	☐	Dizziness		
☐	☐	Palpitations	☐	☐	Sweating		
☐	☐	Dyspnoea	☐	☐	Tremors		
PSYCHOTIC SYMPTOMS				☐ None ☐ N/A			
PAT	FAM	Problem with:	PAT	FAM	Problem with:		
☐	☐	Hallucinations	☐	☐	Behaviour (directing traffic, wandering),		
☐	☐	Delusions,	☐	☐	Negative symptoms(lack of drive or interest in activities)		
☐	☐	Odd or disorganized speech	☐	☐			
MENTAL ILLNESS INDICATORS IN CHILDHOOD: ☐ None ☐ N/A							
PAT	FAM	Problem with:	PAT	FAM	Problem with:		
☐	☐	Hyperactivity	☐	☐	Poor academic performance,		
☐	☐	Poor concentration	☐	☐	Repetitive or stereotypical behaviour,		
☐	☐	Aggressive or disobedient	☐	☐	Language difficulties,		
☐	☐	Withdrawal or isolation,	☐	☐	Mood symptoms and/or psychotic symptoms.,		
PAST PSYCHIATRIC HISTORY:				☐ None ☐ N/A			
PAT	FAM	History of:	PAT	FAM	History of:		
☐	☐	Previous contact with mental health services,	☐	☐	History of being on psychiatric medication		
☐	☐	Previous admission to psychiatric unit or hospitals, and	☐	☐	Compliance patterns (poor, patchy or full compliance)		
RISK ASSESMENT:				☐ None ☐ N/A			
PAT	FAM	Risk of :	PAT	FAM	Risk of :		
☐	☐	Absconding	☐	☐	Harm to others		
☐	☐	Self-harm	☐	☐	Non-compliance.		
Relevant Medical History: see from the summary sheet etc. Screen for chronic diseases - DM, HIV and TB, treatment, maintenance, and compliance.							
Screen for Substance Use: Tobacco / Alcohol / Cannabis / Cocaine / CAT or Tik / Heroin (nyaope) / Benzos / OTC analgesics / other -							
Current medication:				Forensic history ☐ Yes ☐ No: Details if yes:			

EXAMINATION MENTAL HEALTH 1 ST VISIT		Make additional notes here	
EXAMINATION	MENTAL STATE A- Appearance (grooming and dress sense) T- Thoughts: Content, form, speed, speech change-pressure or poverty. O- Orientation to time, place and person. E- Emotions, mood changes and behavioural changes. L- Level of consciousness. I-Insight into condition and medication. M- Memory short term and long-term memory. P- Perception presence of hallucinations (auditory or visual) and delusions (false beliefs).		
MENTAL HEALTH PHYSICAL EXAMINATIONS	Do a basic physical examination: JACCOLD, Respiratory, Central Nervous System and Cardiovascular System (if safe to perform)		
LIFESTYLE MANAGEMENT	Increase physical activity/exercise goal/progress Reducing/ stop tobacco goal/progress Reduce /stop alcohol intake/ Substance abuse Restrict salt intake: Nutrition goal/progress		
SUPPORT AND COUNSELLING	Discuss Support/ Counselling Discuss side effects of Medication Relative/family counselling and support		
ASSESSMENT and FINAL DX and PLAN	Psychiatric /Social /Physical health problem Plan: Admit psyching psychiatric clinic: ☐ Yes ☐ No		
Special investigations	☐ Screening for cannabis - urine specimen ☐ Baseline bloods ☐ GxP with productive cough ☐ ECG-complains of chest pain		
No. of months/ cycles treatment given			
Referred to: In PHC Facility – ☐ Dr ☐ PHCN ☐ Social Worker ☐ OT ☐ Physio ☐ Psychologist ☐ Counsellor ☐ Other: To Hospital – ☐ Psych ☐ Medicine ☐ Surgery ☐ Gynae ☐ Other: External - ☐ Social Welfare ☐ FAMSAs ☐ SANCA ☐ Substance Rehab ☐ Other:			
DATE OF NEXT VISIT:			
HCP NAME:		HPCSA/SANC NR:	HCP SIGNATURE: Nurse/doctor

NEWLY DIAGNOSED / 6 MONTHLY OR ANNUAL REVIEW: Please complete this when a patient is newly diagnosed for a non-communicable disease OR is seen for the 6 monthly/ annual review for ALL chronic diseases. (Tick only what is applicable/ appropriate or a positive finding)			
DATE OF REVIEW:		☐ Newly Diagnosed NCD	☐ 6 Monthly Review ☐ Annual Review
HIV and TB ☐ N/A ☐ None	☐ Opportunistic Infections ☐ TB Contact ☐ Previous TB Tx ☐ Haemoptysis ☐ Numb Feet ☐ Headache ☐ Neck Stiffness ☐ Blurred Vision		☐ Do Bloods/Check results ☐ GeneXpert ☐ Screening
DIABETES HYPERTENSION ☐ N/A ☐ None	☐ Ischaemic Chest Pain ☐ Exertional Dyspnoea ☐ Paroxysmal Nocturnal ☐ Dyspnoea ☐ Orthopnoea	☐ Oliguria ☐ Oedema Lower Limbs ☐ Intermittent Claudication	☐ Blurred / Decreased vision ☐ Cold / Burning / Numb / Tingling of Feet
ASTHMA, CHRONIC OBSTRUCTIVE AIRWAY DISEASE (COPD) ☐ N/A ☐ None	On oxygen therapy: ☐ Any Problems: _____ Day Time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze Night-time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze ☐ Night Awakenings ☐ Previous Hospital/ ICU Admissions No. of Admissions in the Last 12 Months: _____		History of Atopy/ Allergy: ☐ Allergic rhinitis ☐ Conjunctivitis ☐ Eczema Possible Known Allergies: ☐ Dust ☐ Pets ☐ Strong smell (frying, perfume, chemicals) ☐ Exercise ☐ Freshly Cut Grass ☐ Work related ☐ Other: _____
EPILEPSY ☐ N/A ☐ None	Frequency of Epileptic Fits: _____ Type of Seizure: ☐ Generalized Tonic Clonic ☐ Absence Seizures ☐ Partial Seizures ☐ Other: _____ Triggers of Recurrent Epileptic Fits: ☐ Stressful Situations ☐ Emotional Situations ☐ Defaulted Medication ☐ Light: Computer / Very Bright Light / Flashing		History of Head Injury: ☐ Yes ☐ No Year Injured: _____ History of Birth Injury: ☐ Yes ☐ No Type of Injury: _____
MENTAL HEALTH ☐ N/A ☐ None	☐ Psychotic Symptoms ☐ Odd Behaviour ☐ Hallucinations ☐ Suicidal Thoughts/ Ideation ☐ Depressed Mood ☐ Anxiety ☐ Substance Abuse: _____		☐ Psychosocial Stress ☐ Drug Side Effects ☐ Poor Sleeping and Eating Patterns
MUSCULOSKELETAL ☐ N/A ☐ None			
NEUROLOGICAL ☐ N/A ☐ None			
GENERAL/ OTHER ☐ N/A ☐ None			
PHYSICAL EXAMINATION: If any positive finding, please refer to the appropriate service/ discipline			
GENERAL			
MENTAL STATE EXAM (MSE)	☐ Behaviour/ Appearance ☐ Self-Care ☐ Mood ☐ Psychotic Symptoms ☐ Investigations, ☐ Screening & ☐ Bloods done		
CARDIOVASCULAR SYSTEM	☐ Murmur ☐ S ₃ ☐ Gallop ☐ Oedema ☐ Raised JVP ☐ Bruit ☐ Radio-Femoral Delay: _____ seconds		
RESPIRATORY SYSTEM	☐ Crepitations ☐ Wheeze ☐ Cough ☐ Dyspnoea Respiratory Rate: _____		
ABDOMINAL EXAMINATION	☐ Hepatomegaly ☐ Splenomegaly ☐ Mass: ☐ Discolouration		
MUSCULOSKELETAL	☐ Arthritis ☐ Gout ☐ Pain ☐ Deformity ☐ Swelling ☐ Muscle Atrophy ☐ Cramps		
OPHTHALMOSCOPY; Snellen chart	☐ Red Reflex ☐ Exudates: ☐ Soft ☐ Hard ☐ Normal Optic Disc Margin ☐ New Vessel Formation		
FOOT EXAM	☐ Infection ☐ Wounds (Ulcers) ☐ Calluses or corns ☐ Deformities ☐ Swollen Feet ☐ Abnormal Nails ☐ Abnormal Gait ☐ Left Pulses ☐ Right Pulses Other: _____		
TREATMENT/ MX UPDATE/ CHANGE/ REFERRAL			
NAME OF CLINICIAN:	HPCSA OR SANC NUMBER:	SIGNATURE:	
PLEASE ALSO COMPLETE THE CONTINUATION VISIT WHEN DOING A REVIEW			

NEWLY DIAGNOSED / 6 MONTHLY OR ANNUAL REVIEW: <i>Please complete this when a patient is newly diagnosed for a non-communicable disease OR is seen for the 6 monthly/ annual review for ALL chronic diseases.</i> <i>(Tick only what is applicable/ appropriate or a positive finding)</i>			
DATE OF REVIEW:		☐ Newly Diagnosed NCD	☐ 6 Monthly Review ☐ Annual Review
HIV and TB ☐ N/A ☐ None	☐ Opportunistic Infections ☐ TB Contact ☐ Previous TB Tx ☐ Haemoptysis ☐ Numb Feet ☐ Headache ☐ Neck Stiffness ☐ Blurred Vision		☐ Do Bloods/Check results ☐ GeneXpert ☐ Screening
DIABETES HYPERTENSION ☐ N/A ☐ None	☐ Ischaemic Chest Pain ☐ Exertional Dyspnoea ☐ Paroxysmal Nocturnal ☐ Dyspnoea ☐ Orthopnoea	☐ Oliguria ☐ Oedema Lower Limbs ☐ Intermittent Claudication	☐ Blurred / Decreased vision ☐ Cold / Burning / Numb / Tingling of Feet
ASTHMA, CHRONIC OBSTRUCTIVE AIRWAY DISEASE (COPD) ☐ N/A ☐ None	On oxygen therapy: ☐ Any Problems: _____ Day Time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze Night-time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze ☐ Night Awakenings ☐ Previous Hospital/ ICU Admissions No. of Admissions in the Last 12 Months: _____		History of Atopy/ Allergy: ☐ Allergic rhinitis ☐ Conjunctivitis ☐ Eczema Possible Known Allergies: ☐ Dust ☐ Pets ☐ Strong smell (frying, perfume, chemicals) ☐ Exercise ☐ Freshly Cut Grass ☐ Work related ☐ Other: _____
EPILEPSY ☐ N/A ☐ None	Frequency of Epileptic Fits: _____ Type of Seizure: ☐ Generalized Tonic Clonic ☐ Absence Seizures ☐ Partial Seizures ☐ Other: _____ Triggers of Recurrent Epileptic Fits: ☐ Stressful Situations ☐ Emotional Situations ☐ Defaulted Medication ☐ Light: Computer / Very Bright Light / Flashing		History of Head Injury: ☐ Yes ☐ No Year Injured: _____ History of Birth Injury: ☐ Yes ☐ No Type of Injury: _____
MENTAL HEALTH ☐ N/A ☐ None	☐ Psychotic Symptoms ☐ Odd Behaviour ☐ Hallucinations ☐ Suicidal Thoughts/ Ideation ☐ Depressed Mood ☐ Anxiety ☐ Substance Abuse: _____		☐ Psychosocial Stress ☐ Drug Side Effects ☐ Poor Sleeping and Eating Patterns
MUSCULOSKELETAL ☐ N/A ☐ None			
NEUROLOGICAL ☐ N/A ☐ None			
GENERAL/ OTHER ☐ N/A ☐ None			
PHYSICAL EXAMINATION: <i>If any positive finding, please refer to the appropriate service/ discipline</i>			
GENERAL			
MENTAL STATE EXAM (MSE)	☐ Behaviour/ Appearance ☐ Self-Care ☐ Mood ☐ Psychotic Symptoms ☐ Investigations, ☐ Screening & ☐ Bloods done		
CARDIOVASCULAR SYSTEM	☐ Murmur ☐ S ₃ ☐ Gallop ☐ Oedema ☐ Raised JVP ☐ Bruit ☐ Radio-Femoral Delay: _____ seconds		
RESPIRATORY SYSTEM	☐ Crepitations ☐ Wheeze ☐ Cough ☐ Dyspnoea Respiratory Rate: _____		
ABDOMINAL EXAMINATION	☐ Hepatomegaly ☐ Splenomegaly ☐ Mass: ☐ Discolouration		
MUSCULOSKELETAL	☐ Arthritis ☐ Gout ☐ Pain ☐ Deformity ☐ Swelling ☐ Muscle Atrophy ☐ Cramps		
OPHTHALMOSCOPY; Snellen chart	☐ Red Reflex ☐ Exudates: ☐ Soft ☐ Hard ☐ Normal Optic Disc Margin ☐ New Vessel Formation		
FOOT EXAM	☐ Infection ☐ Wounds (Ulcers) ☐ Calluses or corns ☐ Deformities ☐ Swollen Feet ☐ Abnormal Nails ☐ Abnormal Gait ☐ Left Pulses ☐ Right Pulses Other: _____		
TREATMENT/ MX UPDATE/ CHANGE/ REFERRAL			
NAME OF CLINICIAN:		HPCSA OR SANC NUMBER:	SIGNATURE:
PLEASE ALSO COMPLETE THE CONTINUATION VISIT WHEN DOING A REVIEW			

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HIV and TB ☐ N/A ☐ None	☐ Opportunistic Infections ☐ TB Contact ☐ Previous TB Tx ☐ Haemoptysis ☐ Numb Feet ☐ Headache ☐ Neck Stiffness ☐ Blurred Vision		☐ Do Bloods/Check results ☐ GeneXpert ☐ Screening
DIABETES HYPERTENSION ☐ N/A ☐ None	☐ Ischaemic Chest Pain ☐ Exertional Dyspnoea ☐ Paroxysmal Nocturnal ☐ Dyspnoea ☐ Orthopnoea	☐ Oliguria ☐ Oedema Lower Limbs ☐ Intermittent Claudication	☐ Blurred / Decreased vision ☐ Cold / Burning / Numb / Tingling of Feet
ASTHMA, CHRONIC OBSTRUCTIVE AIRWAY DISEASE (COPD) ☐ N/A ☐ None	On oxygen therapy: ☐ Any Problems: _____ Day Time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze Night-time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze ☐ Night Awakenings ☐ Previous Hospital/ ICU Admissions No. of Admissions in the Last 12 Months: _____		History of Atopy/ Allergy: ☐ Allergic rhinitis ☐ Conjunctivitis ☐ Eczema Possible Known Allergies: ☐ Dust ☐ Pets ☐ Strong smell (frying, perfume, chemicals) ☐ Exercise ☐ Freshly Cut Grass ☐ Work related ☐ Other: _____
EPILEPSY ☐ N/A ☐ None	Frequency of Epileptic Fits: _____ Type of Seizure: ☐ Generalized Tonic Clonic ☐ Absence Seizures ☐ Partial Seizures ☐ Other: _____ Triggers of Recurrent Epileptic Fits: ☐ Stressful Situations ☐ Emotional Situations ☐ Defaulted Medication ☐ Light: Computer / Very Bright Light / Flashing		History of Head Injury: ☐ Yes ☐ No Year Injured: _____ History of Birth Injury: ☐ Yes ☐ No Type of Injury: _____
MENTAL HEALTH ☐ N/A ☐ None	☐ Psychotic Symptoms ☐ Odd Behaviour ☐ Hallucinations ☐ Suicidal Thoughts/ Ideation ☐ Depressed Mood ☐ Anxiety ☐ Substance Abuse: _____		☐ Psychosocial Stress ☐ Drug Side Effects ☐ Poor Sleeping and Eating Patterns
MUSCULOSKELETAL ☐ N/A ☐ None			
NEUROLOGICAL ☐ N/A ☐ None			
GENERAL/ OTHER ☐ N/A ☐ None			
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MENTAL STATE EXAM (MSE)	☐ Behaviour/ Appearance ☐ Self-Care ☐ Mood ☐ Psychotic Symptoms ☐ Investigations, ☐ Screening & ☐ Bloods done		
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TREATMENT/ MX UPDATE/ CHANGE/ REFERRAL			
NAME OF CLINICIAN:		HPCSA OR SANC NUMBER:	SIGNATURE:
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DIABETES HYPERTENSION ☐ N/A ☐ None	☐ Ischaemic Chest Pain ☐ Exertional Dyspnoea ☐ Paroxysmal Nocturnal ☐ Dyspnoea ☐ Orthopnoea	☐ Oliguria ☐ Oedema Lower Limbs ☐ Intermittent Claudication	☐ Blurred / Decreased vision ☐ Cold / Burning / Numb / Tingling of Feet
ASTHMA, CHRONIC OBSTRUCTIVE AIRWAY DISEASE (COPD) ☐ N/A ☐ None	On oxygen therapy: ☐ Any Problems: _____ Day Time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze Night-time Symptoms: ☐ Cough ☐ Tight Chest ☐ Wheeze ☐ Night Awakenings ☐ Previous Hospital/ ICU Admissions No. of Admissions in the Last 12 Months: _____		History of Atopy/ Allergy: ☐ Allergic rhinitis ☐ Conjunctivitis ☐ Eczema Possible Known Allergies: ☐ Dust ☐ Pets ☐ Strong smell (frying, perfume, chemicals) ☐ Exercise ☐ Freshly Cut Grass ☐ Work related ☐ Other: _____
EPILEPSY ☐ N/A ☐ None	Frequency of Epileptic Fits: _____ Type of Seizure: ☐ Generalized Tonic Clonic ☐ Absence Seizures ☐ Partial Seizures ☐ Other: _____ Triggers of Recurrent Epileptic Fits: ☐ Stressful Situations ☐ Emotional Situations ☐ Defaulted Medication ☐ Light: Computer / Very Bright Light / Flashing		History of Head Injury: ☐ Yes ☐ No Year Injured: _____ History of Birth Injury: ☐ Yes ☐ No Type of Injury: _____
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MUSCULOSKELETAL ☐ N/A ☐ None			
NEUROLOGICAL ☐ N/A ☐ None			
GENERAL/ OTHER ☐ N/A ☐ None			
PHYSICAL EXAMINATION: <i>If any positive finding, please refer to the appropriate service/ discipline</i>			
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TREATMENT/ MX UPDATE/ CHANGE/ REFERRAL			
NAME OF CLINICIAN:	HPCSA OR SANC NUMBER:	SIGNATURE:	

PLEASE ALSO COMPLETE THE CONTINUATION VISIT WHEN DOING A REVIEW

CONTINUATION SHEET FOR ALL VISITS (Please complete at each visit for ALL patients - including Mental Health patients)			
VISIT DATE:		VISIT DATE 1:	VISIT DATE 2:
HISTORY	New Complaints		
	Psychosocial History		
	STI Screen: High Risk for HIV – Consider PrEP		
	Family Planning/ Condoms/ Pregnancy?		
	Months on TB Rx OR Screen for TB Symptoms		
	Screen for NCD / Mental Health / Cancer		
EXAMINATION	JACCOLD Examine ALL Relevant Systems		
LIFESTYLE MANAGEMENT (Goal / & progress)	Weight Reduction		
	Increase Physical Activity/Exercise		
	Reducing/ Stop Tobacco		
	Reduce/ Stop Alcohol Intake		
	Substance Abuse		
	Restrict Salt Intake		
KNOWN ART PATIENT	Months on Haart Tx		
	Months on Regimen (ART)		
	Which Tx Regimen		
ASSESSMENT and PLAN	Problem List		
	Plan		
	WHO STAGE (if applicable)		
	Has Adherence Support & Counselling been Done?		
	Baseline/ 6 Monthly or Annual Review Done: Y/N & Date of Next Review	☐ Y ☐ N Date:	☐ Y ☐ N Date:
Nr of Months/ Cycles Treatment Given			
Decanted: Y /N & Type		☐ Y ☐ N	☐ Y ☐ N
Referred To:			
Date of Next Visit:			
HCP Name:			
HPCSA/SANC Number:			
HCP Signature: Please State If: Nurse or Doctor			
Data Capturer Name: Signature:			

CONTINUATION SHEET FOR ALL VISITS *(Please complete at each visit for ALL patients - including Mental Health patients)*

[illegible]

DO NOT COPY OR DISTRIBUTE

CONTINUATION SHEET FOR ALL VISITS (Please complete at each visit for **ALL** patients - including Mental Health patients)

VISIT DATE:		VISIT DATE 1:	VISIT DATE 2:
HISTORY	New Complaints		
	Psychosocial History		
	STI Screen: High Risk for HIV – Consider PrEP		
	Family Planning/ Condoms/ Pregnancy?		
	Months on TB Rx OR Screen for TB Symptoms		
	Screen for NCD / Mental Health / Cancer		
EXAMINATION	JACCOLD Examine ALL Relevant Systems		
LIFESTYLE MANAGEMENT (Goal/ & progress)	Weight Reduction		
	Increase Physical Activity/Exercise		
	Reducing/ Stop Tobacco		
	Reduce /Stop Alcohol Intake		
	Substance Abuse		
	Restrict Salt Intake		
	Nutrition		
KNOWN ART PATIENT	Months on Haart Tx		
	Months on Regimen (ART)		
	Which Tx Regimen		
ASSESSMENT and PLAN	Problem List		
	Plan		
	WHO STAGE (if applicable)		
	Has Adherence Support & Counselling been Done?		
Baseline/ 6 Monthly or Annual Review Done: Y/N & Date of Next Review		☐ Y ☐ N Date:	☐ Y ☐ N Date:
Nr of Months/ Cycles Treatment Given			
Decanted: Y /N & Type		☐ Y ☐ N	☐ Y ☐ N
Referred To:			
Date of Next Visit:			
HCP Name: HPCSA/SANC Number:			
HCP Signature: Please State If: Nurse or Doctor			
Data Capturer Name: Signature:			

CONTINUATION SHEET FOR ALL VISITS *(Please complete at each visit for ALL patients - including Mental Health patients)*

[illegible]

CONTINUATION SHEET FOR ALL VISITS (Please complete at each visit for ALL patients - including Mental Health patients)			
VISIT DATE:		VISIT DATE 1:	VISIT DATE 2:
HISTORY	New Complaints		
	Psychosocial History		
	STI Screen: High Risk for HIV – Consider PrEP		
	Family Planning/ Condoms/ Pregnancy?		
	Months on TB Rx OR Screen for TB Symptoms		
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EXAMINATION	JACCOLD Examine ALL Relevant Systems		
LIFESTYLE MANAGEMENT (Goal/ & progress)	Weight Reduction		
	Increase Physical Activity/Exercise		
	Reducing/ Stop Tobacco		
	Reduce /Stop Alcohol Intake		
	Substance Abuse		
	Restrict Salt Intake		
KNOWN ART PATIENT	Nutrition		
	Months on Haart Tx		
	Months on Regimen (ART)		
ASSESSMENT and PLAN	Which Tx Regimen		
	Problem List		
	Plan		
	WHO STAGE (if applicable)		
	Has Adherence Support & Counselling been Done?		
Baseline/ 6 Monthly or Annual Review Done: Y/N & Date of Next Review		☐ Y ☐ N Date:	☐ Y ☐ N Date:
Nr of Months/ Cycles Treatment Given			
Decanted: Y /N & Type		☐ Y ☐ N	☐ Y ☐ N
Referred To:			
Date of Next Visit:			
HCP Name: HPCSA/SANC Number:			
HCP Signature: Please State If: Nurse or Doctor			
Data Capturer Name: Signature:			

CONTINUATION SHEET FOR ALL VISITS *(Please complete at each visit for ALL patients - including Mental Health patients)*[illegible]

CONTINUATION SHEET FOR ALL VISITS (Please complete at each visit for ALL patients - including Mental Health patients)			
VISIT DATE:		VISIT DATE 1:	VISIT DATE 2:
HISTORY	New Complaints		
	Psychosocial History		
	STI Screen: High Risk for HIV – Consider PrEP		
	Family Planning/ Condoms/ Pregnancy?		
	Months on TB Rx OR Screen for TB Symptoms		
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EXAMINATION	JACCOLD Examine ALL Relevant Systems		
LIFESTYLE MANAGEMENT (Goal/ & progress)	Weight Reduction		
	Increase Physical Activity/Exercise		
	Reducing/ Stop Tobacco		
	Reduce /Stop Alcohol Intake		
	Substance Abuse		
	Restrict Salt Intake		
KNOWN ART PATIENT	Nutrition		
	Months on Haart Tx		
	Months on Regimen (ART)		
ASSESSMENT and PLAN	Which Tx Regimen		
	Problem List		
	Plan		
	WHO STAGE (if applicable)		
	Has Adherence Support & Counselling been Done?		
Baseline/ 6 Monthly or Annual Review Done: Y/N & Date of Next Review		☐ Y ☐ N Date:	☐ Y ☐ N Date:
Nr of Months/ Cycles Treatment Given			
Decanted: Y /N & Type		☐ Y ☐ N	☐ Y ☐ N
Referred To:			
Date of Next Visit:			
HCP Name: HPCSA/SANC Number:			
HCP Signature: Please State If: Nurse or Doctor			
Data Capturer Name: Signature:			

CONTINUATION SHEET FOR ALL VISITS *(Please complete at each visit for ALL patients - including Mental Health patients)*[illegible]

CONTINUATION CLINICAL/ PROGRESS NOTES

Date and Time	Remarks	Name (Print), Qualifications, HPCSA/SANC Nr, Signature

CONTINUATION CLINICAL/ PROGRESS NOTES

Date and Time	Remarks	Name (Print), Qualifications, HPCSA/SANC Nr, Signature

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CONTINUATION CLINICAL/ PROGRESS NOTES

Date and Time	Remarks	Name (Print), Qualifications, HPCSA/SANC Nr, Signature

CONTINUATION CLINICAL/ PROGRESS NOTES

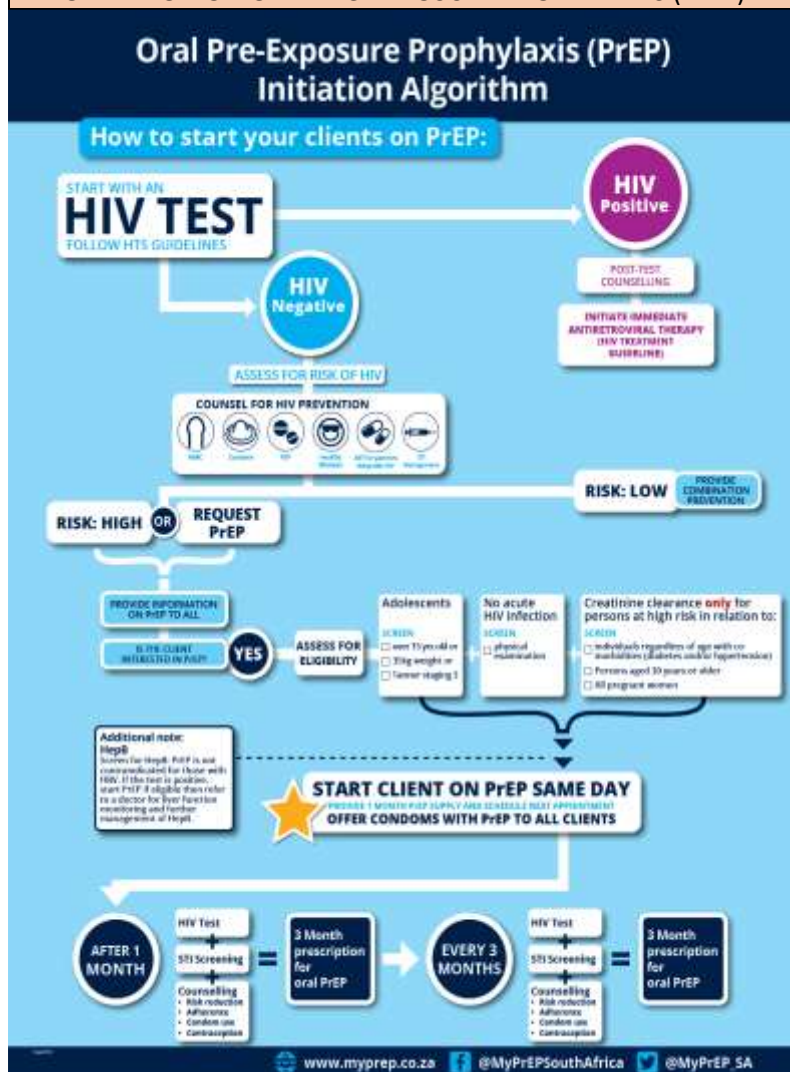
Date and Time	Remarks	Name (Print), Qualifications, HPCSA/SANC Nr, Signature

PRESCRIPTION SHEET <i>for recording 1st time given and repeats</i>			Drug Allergies:						
	DATE TIME	DETAILS OF THE PRESCRIPTION- 1 ST TIME PRESCRIBED	DATE OF REPEATS						
1		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
2		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
3		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
4		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
5		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
6		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
7		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
8		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
9		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
10		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						
11		PATIENT DETAIL:	Quantity						
			Batch Number						
		PRESCRIBER NAME, SIGNATURE, QUALIFICATIONS, HPCSA/SANC NR	Dispense Sign						
			Print Name						
		PATIENT SIGNATURE FOR RECEIVING THE MEDICATION	Patient Sign						

Drug Side Effects:										
	DATE OF REPEATS									
1	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
2	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
3	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
4	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
5	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
6	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
7	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
8	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
9	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
10	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									
11	Quantity									
	Batch Number									
	Dispense Sign									
	Print Name									
	Patient Sign									

ADHERENCE SUPPORT FOR CHRONIC CONDITIONS (HAART, NCD, Mental Health)	
FTIC Session 1 after chronic disease education session (Date Assessment Made):	
Adherence Step 1: Education on HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Other ☐	
Adherence Step 2: Life goals: My motivation to stay healthy are: (1)..... (2)..... (3)..... I will maintain a healthy lifestyle by ☐ Adopting healthy eating habits ☐ Getting regular exercise ☐ Managing my stress	
Adherence Step 3: Patient Support System Agree for home visit: Yes ☐ No ☐ Preferred means of contact: ☐ SMS ☐ WhatsApp ☐ Phone call ☐ Other ☐ Who can support me in my treatment: ☐ Family ☐ Friend ☐ Work ☐ School ☐ Church ☐ Other:	
Adherence Step 4: Getting to appointments I will come to my appointment by: ☐ Walk ☐ Public transport ☐ Own transport If I face a difficulty to come (money, transport, etc), my alternative plan will be to ask for assistance from: ☐ Family ☐ Friends ☐ Neighbour ☐ Other..... I will inform the clinic; I am unable to come to set appointment and request for an alternative appointment ☐	
Adherence Step 5: My readiness to start treatment I feel ready and will start treatment: ☐ Yes I am ready today ☐ Yes ☐ No but will be on..... (insert date) ☐ I do not feel ready and would like to discuss more with: ☐ Peer ☐ Family member ☐ Other.....	
FTIC Session 2 (Date Assessment Made):	
Adherence Step 6: Medication schedule The best time for me to take my treatment is: ☐ Morning ☐ Afternoon ☐ Evening	
Adherence Step 7: Managing missed doses If I miss a dose, my plan is: (1) to take treatment as soon as I remember ☐	
Adherence Step 8: Reminder strategies To remind me to take medication I will use: ☐ Watch ☐ Cell phone alarm ☐ Pill box ☐ Buddy ☐ Other.....	
Adherence Step 9: Storing medication and extra doses I will store my medication in: ☐ Safe place: ☐ Far from reach of children I will carry extra supply in: ☐ A bag ☐ Pill box ☐ Other: will keep it in my: ☐ Handbag ☐ Pocket ☐ Other:	
Adherence Step 10: Dealing with side-effects If I experience side effects, I will: Refer to treatment adherence pamphlet ☐ Inform clinic if side effect does not go away or are too worrying ☐	
FTIC Session 3 (Date Assessment Made):	
Adherence Step 11: Understanding the treatment pathway ahead of me if I take my treatment well ☐ I understand the options for multi-month treatment supply and simplified collection available after 6 months on treatment	
Adherence Step 12: Planning for trips <i>If I have some trips planned, before going away I will:</i> ☐ Inform health facility before travelling to receive referral letter and treatment ☐ Get enough supply of treatment for trip <i>In case I cannot come to the facility before going away:</i> ☐ I will report to the nearest health facility in the travel area as soon as I arrive to get access to treatment ☐ Carry evidence pf my condition and evidence of the treatment I am taking	
Adherence Step 13: Dealing with substance use <i>My plan to make sure I take my medication if I used alcohol or drug is:</i> ☐ To make sure I take treatment before starting to use drugs and alcohol ☐ Arrange for someone to remind me to take treatment in case I am intoxicated	
FTIC Session 4 (Date Assessment Made):	
Education on assessment: Viral load ☐ Sputum ☐ HbA1c ☐ BP ☐ Other: ☐ I understand that I can access multi-month treatment supply and simplified collection after 6 months treatment if my results are normal	
Patients signature Date of signature/...../.....	
EAC Session 1 (date):	
EAC Session 2 (date):	

ADDITIONAL COUNSELLING							
All Chronic Disease Counselling: Pre-ART/ NCD/ Mental Health / Other – Counsel according to the disease							
Session	Date/s	Counsellor Group	Tx Buddy Attendance	Comments			
General Education and Healthy living (HIV/NCD/Mental)							
Medication Therapy (ART/NCD/Mental)							
Adherence Planning							
Other							
Belong to a support group: HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Mental Other ☐ Date started support group: _____							
EXPERIENCE WITH DECANTING: Type of decanting: _____ Date Decanted 1 st time: ____/____/____ (Note any problems picked up after decanting e.g., not picking up repeats form decanting sites etc (SYNC reports))							
TRACING RECORD: For a Patient That Has Missed an Appointment or Defaulted Treatment							
Today date	Date last appointment	Action taken to trace patient	Outcome of tracing Lost to follow up/defaulted/reinitiated	Date pat returned to facility	Name and sig	Comments	
INSULIN AND DIABETIC COUNSELLING: START DATE INSULIN: ____/____/____							
Topic	Date Discussed	Topic	Date Discussed	Topic	Date Discussed	Topic	Date Discussed
Importance of insulin injection site rotation		Insulin Types and action		Blood glucose monitoring		Nutrition consultation	
Location of sites/ needle length		Storage of insulin medication		Management of hypoglycaemia		General Management	
Sharp disposals				Management of hyperglycaemia			
Additional Comments:							



STEPS TO PrEP INITIATION/ RE-INITIATION

#	Date of Visit	HIV Result	PrEP Counselling Done Y/ N	Proceed with Screening? Y/ N	Creatinine (eGFR)	Pregnant	Weight (kgs)	Hep B Result	STI Screen	Initiate? Y/ N
1			Y N	Y N						Y N
2			Y N	Y N						Y N
3			Y N	Y N						Y N
4			Y N	Y N						Y N
5			Y N	Y N						Y N

PATIENT CLIENT REFERRAL FORM TEMPLATE

FACILITY DETAILS: Facility Name/ Address/Tel Number:

HEALTH PRACTITIONER DETAILS: Name of Referring Practitioner/Tel Number/Email

PATIENT/ CLIENT PARTICULARS: Name/Surname / Date of Birth / Address/ Tel Number:

Provisional Diagnosis/ Differential Diagnosis/ Reason for Referral

Reason for Referral:

RELEVANT HISTORY/ PRESENTING COMPLAINT: (Include relevant travel, medical & surgical history and any allergies/ medication patient is on)

RELEVANT VITAL/ EXAMINATION DATA: BP; HR; Temp; Resp; Weight; Urine; HGT; HB

Other Tests/ Investigations Done/ Examination Findings:

RELEVANT MANAGEMENT/ TREATMENT GIVEN: (Include relevant management and treatment done for patient at facility level prior to referral e.g., procedures done, and medication given)

Additional Comments:

Signature of HCP:

Date:

INTEGRATED CARE OF PATIENTS WITH CHRONIC CONDITIONS

