D FOLLOW-UP FORM

DISEASE MANAGEMENT FORM

ADULTS AND PAEDIATRICS

Forward to: MyHealth Administrators, Maerua Office Park, Robert Mugabe Avenue, Windhoek
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Administrators of **Vitality**
Private Medical Aid Funds
RCC
Renaissance Medical Aid
Employer Groups

Aids Outreach Programme
Namibia Medical Care
Bankmed Namibia

Metropolitan Workplace Solutions

1. **Patient Name**.....**Date**.....

2. **Weight**.....kg
   BP.....mmHg
   Pulse.....
   Temp.....
   Ht/lenght (Paeds).....cm

3. **Adherence Assessment**
   ☐ Pill count .....
   ☐ Patient's self report

4. **Pregnant?**
   ☐ Yes
   ☐ No
   LMP.....
   EDD.....

5. **Side effects/toxicities**:
   ☐ Neuropathy ☐ Lipoatrophy ☐ Nephrolitihiasis
   ☐ Rashes ☐ Others ☐ Stevens-Johnson's ☐ Hepatitis
   ☐ Lactic acidosis ☐ Pancreatitis ☐ Fat accumulation (state site).....

6. **Cotrimoxazole prophylaxis:**
   ☐ Start
   ☐ Continue
   ☐ Stop

7. **Decision for ARV regimen**
   ☐ Continue
   ☐ Change
   ☐ Stop

8. **Reason(s) for changing/stopping** ☐ Toxidity
   ☐ Side-effects ☐Pregnancy
   ☐ Treatment Failure ☐ Non-adherence
   ☐ Others ☐ Completion of PMTCT/PEP

9. **New regimen prescribed**

Medication	Dose/frequency

10. **Supporting laboratory results for change of regimen**

Date	Test	Value	Date	Test	Value
	CD4 +%				
	Viral load				

11. **Dose adjustment today? (Paediatrics)** ☐Yes ☐ No

12. **If yes to 12 above, please state new dosages**

ARV	New Dosage

13. **Immune Reconstitution Syndrome (IRS)** ☐ TB ☐ Cryptococcosis ☐ PCP
    ☐ Hepatitis (B, C) ☐ Herpes Zoster ☐ PML ☐ CMV
    ☐ MAC ☐ Herpex simplex ☐ None

14. **Non-ARVs medication(s) prescribed today**.....

15. **Overall clinical assessment compared to previous visit**
    ☐ Stable
    ☐ Improved
    ☐ Deteriorated

16. **New WHO stage /other comments:**.....
    .....
    .....
    .....

17. **Follow-up consultation date**.....

Doctor's name _____ Doctor's signature _____ Date _____

Please fax this form and copies of lab results to: 061-375969.