Pre-Exposure Prophylaxis (PrEP) Facility Record

PrEP file no:

A. Facility information		
Facility Name	District	District clinician/team
Date of initial client visit *(dd/mm/yy)* ____ /____ /____		Person Completing Form

B. Client Demographics		
First Name	Middle Name	Surname
Address	Telephone	
Date of Birth *(dd/mm/yy)* ____ /____ /_____	Unique ID number	
Date of last HIV test: ____ /____ /____ *(dd/mm/yy)* Last eGFR Result :_____ Date: ___/___ /___*(dd/mm/yy)*	Marital status □ Single □ Married □ Divorced □ Widowed □ Separated □ Refused	

C. Sexual and Drug Injection Core Risk Classification

1. Do you consider yourself: male, female, transgender, or other?
- □ Male
- □ Female
- □ Ttransgender, male to female (MTF)
- □ Transgender, female to male (FTM)
- □ Other: _____]
- □ Refuses to answer

2. What was your sex at birth?
- □ Male
- □ Female
- □ Other: _____
- □ Refuses to answer

3. Do you have sex with: □ Men only □ Women only □ Both men and women □ Refuses to answer

4. Have you exchanged sex as your main source of income* in the last <u>six months</u>? □ Yes □ No □ Refuses to answer

**If respondent receives less than half (50%) of their income in exchange for sex, mark NO.*

5. In the last <u>six months</u>, have you injected illicit or illegal drugs? □ Yes □ No □ Refuses to answer

D. Key Population Classification (*an individual can belong to more than one category*)	
If client answers "Male" to question 1 and answers "Men only" or "Both men and women" to question 3, then categorize as MSM	□
If client answers "Transgender MTF" or "FTM" to question 1, then categorize as transgender (cross-check with question 2)	□
If client answers "Yes" to question 4, then categorize as sex worker	□
If client answers "Yes" to question 5, then categorize as person who injects drugs	□

Final Classification: (*mark ALL that apply)**

□ **Man who has sex with men (MSM)**
□ **Transgender (TG)**
□ **Sex worker (SW)**
□ **Person who injects drugs (PWID)**

***Some clients may belong to more than one category due to overlapping risk behavior**

E. Pregnancy and breastfeeding status	**F. Baseline Laboratory Tests:**
Client currently pregnant? □ Yes □No **Client currently breastfeeding?** □ Yes □No	Creatinine (eGFR): _____

G. Hepatitis B Testing, Vaccination, and Treatment	
Date of HBsAg test: ___/___/____ *(dd/mm/yy)*	**Test result:** □ Negative □ Positive □ Not Done
If positive, is patient on treatment? □ Yes □ No □ Unknown	**If negative, dates HBV vaccination provided:** *(dd/mm/yy)* 1) ____ /____ /____ 2) ____ /____ /____ 3) ____ /____ /____

H. Sexually Transmitted Infections (STI)

VDRL/Syphilis test date: ___/___/____ *(dd/mm/yy)*

Result: □ Negative □ Positive □ Not done □Other _____

Syndromic STI screen date: ____ /____ /____ *(dd/mm/yy)*

Result: _____

STI syndromes *(select all that apply)*: U=Urethral discharge / G=Genital ulcers / V=Vaginal discharge / L=Lower abdominal pain / S=Scrotal swelling / I=Inguinal bubo / O=Other-specify

STI ecological diagnosis: _____

If STI diagnosis, date started treatment: ___/___/___ *(dd/mm/yy)*

I. Initiation of PrEP Treatment	
PrEP start date	___/___/____ (dd/mm/yy)
PrEP (ARVs) prescribed	□ TDF/FTC □ TDF/3TC □ TDF □ Other: _____
PrEP discontinued	**Date discontinued:** ___/___/____ (dd/mm/yy)
	Reasons for stopping PrEP: □ Tested HIV+ □ No longer at substantial risk □ Side effects □ Client preference □ Other: _____
	HIV status at the time of discontinuation: □ Negative □ Positive □ Unknown

PrEP Follow-up Visits

Follow-up date *(dd/mm/yy)*	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Repeat HIV test *Test result:*	□ Negative □ Positive	□ Negative □ Positive	□ Negative □ Positive	□ Negative □ Positive	□ Negative □ Positive	□ Negative □ Positive	□ Negative □ Positive
Tests Used:	1st :_____ Confirmatory: _____ Other:_____	1st :_____ Confirmatory: _____ Other:_____	1st :_____ Confirmatory: _____ Other:_____	1st :_____ Confirmatory: _____ Other:_____	1st :_____ Confirmatory: _____ Other:_____	1st :_____ Confirmatory: _____ Other:_____	1st :_____ Confirmatory: _____ Other:_____
Asked about signs and symptoms of acute HIV infection?	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Side-effects (see codes)							
eGFR estimate							
New STI diagnosed?	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Adherence: Number of missed tablets in past 7 days	□ 2+ tablets □ <2 tablets □ Unknown	□ 2+ tablets □ <2 tablets □ Unknown	□ 2+ tablets □ <2 tablets □ Unknown	□ 2+ tablets □ <2 tablets □ Unknown	□ 2+ tablets □ <2 tablets □ Unknown	□ 2+ tablets □ <2 tablets □ Unknown	□ 2+ tablets □ <2 tablets □ Unknown
Adherence counseling provided? (tick box if yes)	□	□	□	□	□	□	□
Risk reduction counseling provided?	□	□	□	□	□	□	□
Condoms provided?	□	□	□	□	□	□	□
Currently pregnant or breastfeeding?	□	□	□	□	□	□	□
Repeat PrEP prescription		□ TDF/FTC □ TDF/3TC □ TDF	□ TDF/FTC □ TDF/3TC □ TDF	□ TDF/FTC □ TDF/3TC □ TDF	□ TDF/FTC □ TDF/3TC □ TDF	□ TDF/FTC □ TDF/3TC □ TDF	□ TDF/FTC □ TDF/3TC □ TDF
ARVs prescribed:	□ TDF/FTC □ TDF/3TC □ TDF	# of tablets: __	# of tablets: __	# of tablets: __	# of tablets: __	# of tablets: __	# of tablets: __
Number of tablets:	# of tablets: __						
Next scheduled visit date: *(dd/mm/yy)*	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Notes:							

Side effects: **A**= Abdominal pain; **S**=Skin rash; **Nau**=Nausea; **V**=Vomiting; **D**=Diarrhea; **F**=Fatigue; **H**=Headache; **L** = Enlarged lymph nodes; **R**= Fever ; **O**= Other (specify)