HIGH VIRAL LOAD REGISTER

ART/ Clinic Number	Full name	DOB (DD-MM-YYYY)/Age	Sex	Current ART regimen	Reason for VL test 1. Routine monitoring 2. Repeat after Enhanced Adherence Counseling (EAC) 3.Suspected treatment failure	Date Sample collected (DD-MM-YYYY)	VL Result in copies/mL	Date results received by facility	First EAC (Date) (DD-MM-YYYY)	Second EAC (Date) (DD-MM-YYYY)	Third EAC (Date) (DD-MM-YYYY)	If further EAC sessions write date (DD-MM-YYYY)	If further EAC sessions write date (DD-MM-YYYY)	Date Repeat VL taken (DD-MM-YYYY)	Repeat VL Result in copies/mL	Date results received by facility (DD-MM-YYYY)	Date client received result (DD-MM-YYYY)	Outcome: 1.Switched regimen 2.Remained on current regimen 3. Other (e.g. Transferred out, deceased, referred)	ARV regimen if switched	Outcome date (DD-MM-YYYY)	Date Repeat VL taken (DD-MM-YYYY)	Repeat VL Result in copies/mL	Comments
	Upper space: First name																						
	Lower Space: Last Name																						