FEDERAL MINISTRY OF HEALTH OF ETHIOPIA

HIV Care/ ART Clinic Intake form

G. ART ASSESSMENT AND PLAN

Health Facility Name:_____ Date:_____/_____/_____

PATIENT IDENTIFICATION

Name: _____ Father's Name:_____ Grandfather's Name:_____

ART Unique ID No.: _____ Patient Card No.: _____/_____

ARV ELIGIBILITY CRITERIA

Clinical Criteria:

CD4 below 200	o Yes	o No
WHO Stage IV	o Yes	o No
Who Stage II and III with TLC≤1200	o Yes	o No

Social Criteria:

Resident of catchments area	o Yes	o No
No identified barriers for adherence	o Yes	o No

PLAN

1. OI Prophylaxis (dd/mm/yy)

Cotrimoxazole: Start___/___/___ Continue___/___/___ Discontinue___/___/___ Start at a later date___/___/_____

INH: Start___/___/___ Continue___/___/___ Discontinue___/___/___ Start at a later date___/___/_____

Fluconazole: Start___/___/___ Continue___/___/___ Discontinue___/___/___ Start at a later date___/___/_____

2. Treatment for other conditions: o **Yes**_____ o **No**_____

If Yes: Diagnosis:_____ Treatment: _____

If Yes: Diagnosis: _____ Treatment: _____

3. Recommend ART

o Yes _____ o No _____ o Deferred (State reason) _____

If yes, specify regimen:

- o 1a(30) = d4t (30)-3TC-NVP
- o 1a(40) = d4t (40)-3TC- NVP
- o 1b(30) = d4t (30)-3TC-EFV
- o 1b(40) = d4t (40)-3TC-EFV
- o 1c = AZT-3TC-NVP
- o 1d = AZT-3TC-EFV