**Pre-Exposure Prophylaxis (PrEP) Facility Record**

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| **Date** *(dd/mm/yyyy)* | | **Person Completing Form** | | | |
| **A. Facility Information** | | | | | |
| **Facility Name** | **District** | | |  | |
| **Date of Initial PrEP Client Screening Visit**  *(dd/mm/yyyy):* / / | | | | **PrEP Client Number** *(if applicable)* | |

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| **B. Client Demographics** | | |
| **First/Given Name:** | **Middle Name:** | **Surname:** |
| **Address:** | **Telephone:**  **Telephone (alternative):** | |
| **Date of Birth** *(dd/mm/yyyy)*\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ | **Age** *(years)***:** | |
| **Client ID Number:** | **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ No response | |

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| **C. Sexual and Drug Injection Core Risk Classification** | | | |
| **1. Do you consider yourself: male, female, transgender, or other?**  ❑ Male  ❑ Female  ❑ Transgender, male to female (MTF)  ❑ Transgender, female to male (FTM)  ❑ Other *(specify):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ No response | | **2. What was your sex at birth?**  ❑ Male  ❑ Female  ❑ Other *(specify):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ No response | |
| **3. Do you have sex with:** | ❑ Men only ❑ Women only ❑ Both men and women ❑ No response | | |
| **4. Have you exchanged sex as your main source of income in the last 6 months?** | | | ❑ Yes ❑ No ❑ No response |
| **5. In the last 6 months, have you injected illicit or illegal drugs?** | | | ❑ Yes ❑ No ❑ No response |
| **6. Are you incarcerated?** | | | ❑ Yes ❑ No ❑ No response |

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| 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 man who has sex with men (MSM) | | | ❑ |
| If client answers “Transgender MTF” or “FTM” to question 1, then categorize as transgender (TG) (cross-check with question 2) | | | ❑ |
| If client answers “Yes” to question 4, then categorize as sex worker (SW) | | | ❑ |
| If client answers “Yes” to question 5, then categorize as person who injects drugs (PWID) | | | ❑ |
| If client answers “Yes” to question 6, then categorize as person in prison (PP) | | | ❑ |
| If client is not transgender (TG) and answers “No” or “No response” to questions 3-7, classify as None | | | ❑ |
| Man who has sex with men (MSM)  Transgender (TG)  Sex worker (SW)  Person who injects drugs (PWID)  Person in prison (PP)  Other *(specify)*  None | **Final Classification**:  (*Mark ALL that apply\**)  ❑ MSM  ❑ TG  ❑ SW  ❑ PWID  ❑ PP  ❑ Other *(specify):\_\_\_\_\_\_\_*  ❑ None | *\*Some clients may belong to more than one category due to overlapping risk behavior.* |  |

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| **E. IF FEMALE: Pregnancy & Breastfeeding** | **F. Baseline Laboratory Tests** |
| **Client currently pregnant?** ❑ Yes ❑ No  **Client currently breastfeeding?**❑ Yes ❑ No | Date of last HIV test *(dd/mm/yyyy):*\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_  Date of creatinine test *(dd/mm/yyyy):*\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ ❑ Not done  Calculated creatinine clearance (CrCl): \_\_\_\_\_\_\_\_\_\_\_\_\_ ❑ Not done  Date of creatinine clearance (CrCl) *(dd/mm/yyyy):* / / |

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| **G. Hepatitis B Testing, Vaccination, and Treatment** | |
| **Date of HBsAg test** *(dd/mm/yyyy):* / / | **Test result:** ❑ Negative ❑ Positive ❑ Not done |
| **If positive, client on treatment?** ❑ Yes ❑ No ❑ Unknown | **If negative, dates HBV vaccination provided** *(if available):* *(dd/mm/yyyy)*  1) \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_ 2) \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_  3) / / ❑ Not done |

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| **H. Sexually Transmitted Infections (STI)** |
| **STI symptom screen date** *(dd/mm/yyyy):* **\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_** **Result** *(\*see codes)****:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Not done  **\* STI symptom codes** *(select all that apply)*: **U**=Urethral discharge. **G**=Genital ulcers or lesions. **V**=Vaginal discharge.  **I**=Itching. **L**=Lower abdominal pain *(women only).* **S**=Scrotal swelling. **B**=Bubo in inguinal area.  **D**=Dysuria (pain with urination). **P**=Pain with intercourse *(women only)*. **O**=Other *(specify)*  **If STI syndromic management, syndrome treated** *(\*\*see codes):* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** ❑ Not done  **\*\* STI syndrome codes** *(select all that apply)*: **GUS**=Genital ulcer syndrome. **VDS**=Vaginal discharge syndrome.  **LAP**=Lower abdominal pain. **MUS**=Male urethritis syndrome. **SSW**=Scrotal swelling. **O**=Other *(specify)*  **STI treatment start date** *(dd/mm/yyyy):* / / ❑ Not started treatment |

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| **I. Initiation of PrEP Treatment** | |
| **PrEP start date** | **Date initiated** *(dd/mm/yyyy):* / / |
| **PrEP (ARVs) prescribed** | ❑ TDF/FTC ❑ TDF/3TC ❑ TDF ❑ Other *(specify):* |
| **PrEP discontinued** | **Date discontinued** *(dd/mm/yyyy):* / / |
| **Reasons for stopping PrEP:** ❑ Tested HIV+ ❑ No longer at substantial risk ❑ Side effects ❑ Client preference ❑ Abnormal creatinine result  ❑ Other *(specify):* |
| **HIV status at time of discontinuation**: ❑ Negative ❑ Positive ❑ Unknown |
| **Re-start of PrEP** | |
| **PrEP re-start date** | **Date re-initiated** *(dd/mm/yyyy):* / / |
| **PrEP (ARVs) prescribed** | ❑ TDF/FTC ❑ TDF/3TC ❑ TDF ❑ Other *(specify)*: |
| **PrEP discontinued** | **Date discontinued** *(dd/mm/yyyy):* / / |
| **Reasons for stopping PrEP:** ❑ Tested HIV+ ❑ No longer at substantial risk ❑ Side effects ❑ Client preference ❑ Abnormal creatinine result  ❑ Other *(specify)*: |
| **HIV status at time of discontinuation**: ❑ Negative ❑ Positive ❑ Unknown |

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| **J. Transfer Out, Death, and Loss to Follow-Up** | |
| ❑ **Transferred out (TO)** | **Date TO** *(dd/mm/yyyy):* \_\_\_ /\_\_\_/\_\_\_\_\_\_  **Name of clinic transferred to:** |
| **❑ Died** | **Date of death** *(dd/mm/yyyy):* / / |
| **❑ Lost to follow-up (LTFU)** | **Date confirmed LTFU** *(dd/mm/yyyy):* / / |

**PrEP Follow-Up Visits**

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| **Date of visit** *(dd/mm/yyyy)* **(starting with screening visit)** | \_\_\_ /\_\_\_ /\_\_\_\_\_ | \_\_\_ /\_\_\_ /\_\_\_\_\_ | \_\_\_ /\_\_\_ /\_\_\_\_\_ | \_\_\_ /\_\_\_ /\_\_\_\_\_ | \_\_\_ /\_\_\_ /\_\_\_\_\_ | \_\_\_ /\_\_\_ /\_\_\_\_\_ | \_\_\_ /\_\_\_ /\_\_\_\_\_ |
| **HIV test** Test result:  *Tests Used:* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* | ❑ Negative  ❑ Positive  ❑ Inconclusive  *First:*  *\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Confirmatory: \_\_\_\_\_\_\_\_\_\_\_\_\_* |
| **Signs and symptoms  of acute HIV infection?** | ❑ Yes  ❑ No | ❑ Yes  ❑ No | ❑ Yes  ❑ No | ❑ Yes  ❑ No | ❑ Yes  ❑ No | ❑ Yes  ❑ No | ❑ Yes  ❑ No |
| **PrEP Side effects**  (*see codes* – *insert a dash if none)* |  |  |  |  |  |  |  |
| **CrCl calculation**  (*baseline and every 6 months)* |  |  |  |  |  |  |  |
| **Risk reduction counseling and commodities provided?** (*tick if yes*) | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |
| **PrEP prescription**  *ARVs prescribed (tick)* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* | ❑ TDF/FTC  ❑ TDF/3TC  ❑ TDF  ❑ Other *(specify):* |
| **Next scheduled PrEP visit date** *(dd/mm/yyyy)* | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_ |
| **Additional notes** |  |  |  |  |  |  |  |

**SIDE EFFECT CODES**: **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)*