Pre-Exposure Prophylaxis (PrEP) Facility Record

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)*

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	

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	

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	❑

	Final Classification: *(Mark ALL that apply*)*
Man who has sex with men (MSM)	❑ MSM
Transgender (TG)	❑ TG
Sex worker (SW)	❑ SW
Person who injects drugs (PWID)	❑ PWID
Person in prison (PP)	❑ PP
Other *(specify)*	❑ Other *(specify):*_____
None	❑ None

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

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):* / /

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

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

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

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

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)*