

Adherence Form

Date adherence requested

Tick one: New Initiation 6-Mo Booster Provider initiated booster

____/____/____
DD MM YYYY

Name: _____

Patient ID: _____

Site: _____

Phone Number: _____

Alternate Number: _____

What work do you do now to meet your daily needs? (*purpose: to determine if currently earning an income or not*)
 Current work (specify) _____ Not working now

Medications

ARV regimen: _____, _____, _____ Anti TB medications: _____, _____, _____

Other medications: _____, _____, _____, _____

Adherence Buddy

Do you currently have adherence buddy? Yes No

Buddy's full name: _____ Buddy's relationship: _____

Buddy's phone number: _____ or _____

Adherence Counseling Dates (DD/MM/YYYY)

1ST session ____/____/____

2nd session ____/____/____

3rd session ____/____/____

Booster session ____/____/____

Time Preferred for Taking Pills

AM: ____:____ PM: ____:____

Reminders of Time

- Wall clock Wrist watch Radio
 Mobile clock alarm Sun light shadow Buddy

Disclosure

Have you disclosed your HIV status to any of the following?

- Partner/spouse Children Other, specify: _____
 Not disclosed → *Refer to disclosure counseling*

Alcohol

In the past month, have you taken any alcohol? Yes No

Knowledge of the Following

HIV disease progression <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	What to do if you forget dose, late for dose or vomits after taking pills <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	Duration of treatment/frequency of treatment/time to benefit from treatment <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor
Effects of poor adherence <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	Dangers of sharing medications <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor	Role of ARVs in management of HIV disease <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor
Able to recognise and name the drugs in his/her regimen and can list common side effects, toxicities, and actions to be taken <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor		Risk reduction/Re-infection with HIV/STIs <input type="radio"/> Good <input type="radio"/> Fair <input type="radio"/> Poor

Are you prepared to start ARV medicine? Yes No

Final Assessment

Initiation Session

- Ready for initiation
 Needs reinforcement BEFORE initiation
 Needs continued reinforcement with initiation

Booster Session

- Good adherence knowledge on ART
 Needs reinforcement with continuation of ART
 Needs reinforcement with discontinuation of ART

Comments: _____

Form completed by: CCHA: _____
 (Print name clearly) Nurse: _____
 Clinical Officer: _____
 Medical Officer: _____

