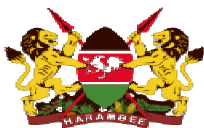


MINISTRY OF PUBLIC HEALTH AND SANITATION & MINISTRY OF MEDICAL SERVICES

HIV Exposed Infant (HEI) Follow Up Card

Name of Facility: ______________ Facility Code: ______________ District: ______________ County: ______________

Cohort by Month and Year of Birth (MM- YYYY) ______________

INFANT PROFILE

HEI Uniqued ID Number: ______________

Name *(First, Middle, Last)* ______________

Sex Male ☐ Female ☐ **Date of Birth** ***(dd-mm-yyyy)*** / / **Birth Weight (kg)** ______________

Date of Enrollment ______________

Source of Referral Ward ☐ OPD ☐ Maternity ☐ CCC ☐ MCH/PMTCT ☐ Other / Specify______________

ARVs Prophylaxis Sd NVP only ☐ NVP for 6 wks ☐ NVP during BF ☐ None ☐ Other/Specify______________

History of TB Contact in Household Yes ☐ No ☐ *If "* ***YES*** *', Screen for TB; and Appropriately refer for INH Prophylaxis*

PARENTS PROFILE

Name of Mother ______________ **Alive?** Yes ☐ No ☐

Mother Received Drugs for PMTCT? Yes ☐ No ☐

If Yes, select combination SdNVP only ☐ AZT from 14 wks ,3TC/ NVP/AZT at delivery, AZT/3TC for 1wk ☐ HAART ☐ Interrupted HAART ☐ None ☐ Other (specify)...............

On ART at enrollment of Infant? Yes ☐ No ☐ **If 'Yes' enter regimen** ______________ **Parent's CCC No.** ______________

Mode of Delivery SVD ☐ C-Section ☐ **Place of Delivery** Facility ☐ Home ☐

IMMUNIZATION HISTORY

BCG ☐ OPV at Birth ☐ OPV 3 ☐ Measles 6Mths ☐

OPV 1 ☐ OPV 2 ☐ Penta 3 ☐ Measles 9 Mths ☐

Penta 1 ☐ Penta 2 ☐ PCV 10-3 ☐ Other (Specify) ______________

PCV 10-1 ☐ PCV 10-2 ☐

Rota 1 ☐ Rota 2 ☐

LABORATORY INFORMATION

Type of Test	Date of Sample Collection	DBS Sample Code	Results		Date Results Collected	Comments:
1st DNA PCR						
Repeat PCR (For Rejections)						
1st Antibody Test @ 9 Months						
Confirmatory PCR, If Antibody is +Ve						
Repeat Confirmatory PCR (For Rejections)						
Final Antibody @ 18 Months						

FINAL HEI OUTCOMES AT EXIT

Discharged at 18 months ☐ Transferred Out ☐ Dead ☐

Referred to CCC ☐ Lost to follow up ☐ Other (Specify) ______________

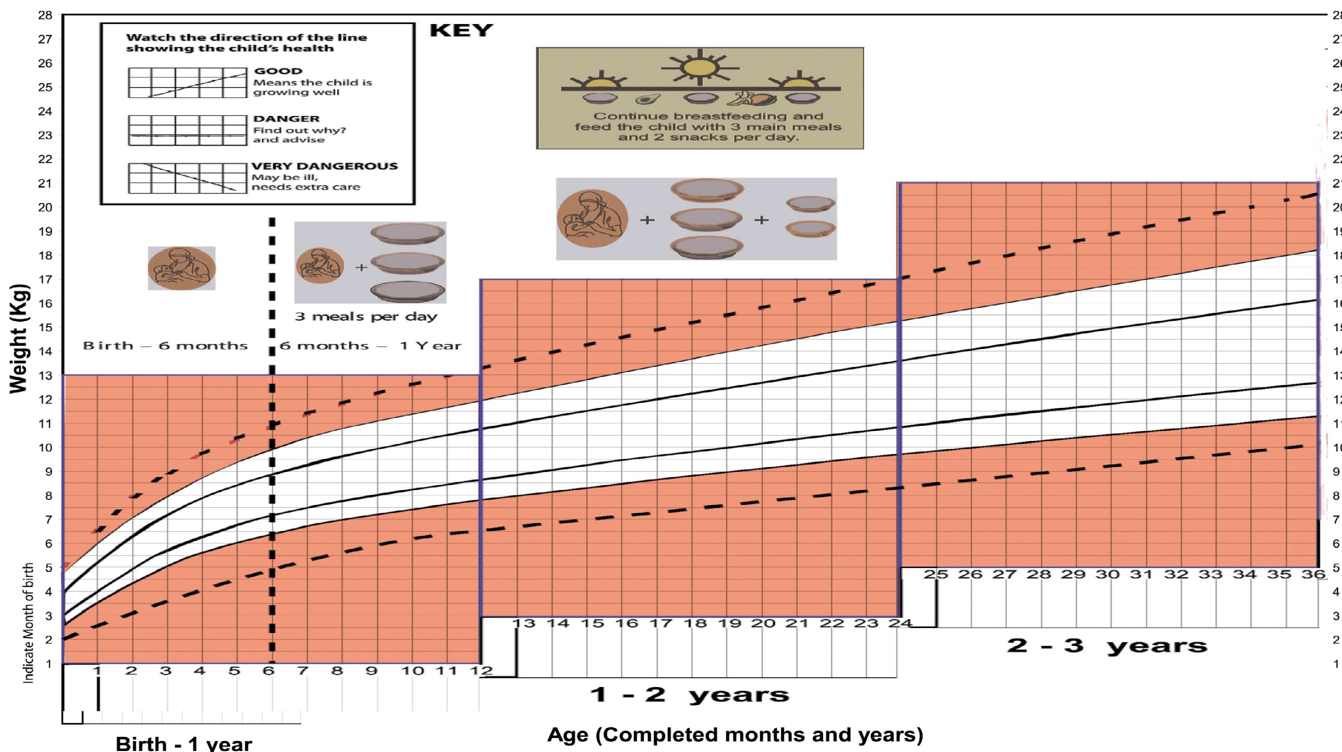
PATIENT LOCATOR INFORMATION

Current Address		Permanent Address	
Is address for	Parent ☐ Guardian ☐	**Is address for**	Parent ☐ Guardian ☐
Name		Name	
Telephone Number		Telephone Number	
County		County	
District		District	
Division		Division	
Location		Location	
Estate / Village		Estate / Village	
Hse / Plot		Hse / Plot	
Sub / Chief's Name		Sub / Chief's Name	
Landmark (e.g School, market)		Landmark (e.g School, market)	

±3 Refer for further investigations
±2 to±3 Refer for nutritional counselling

Weight-for-Age BOYS

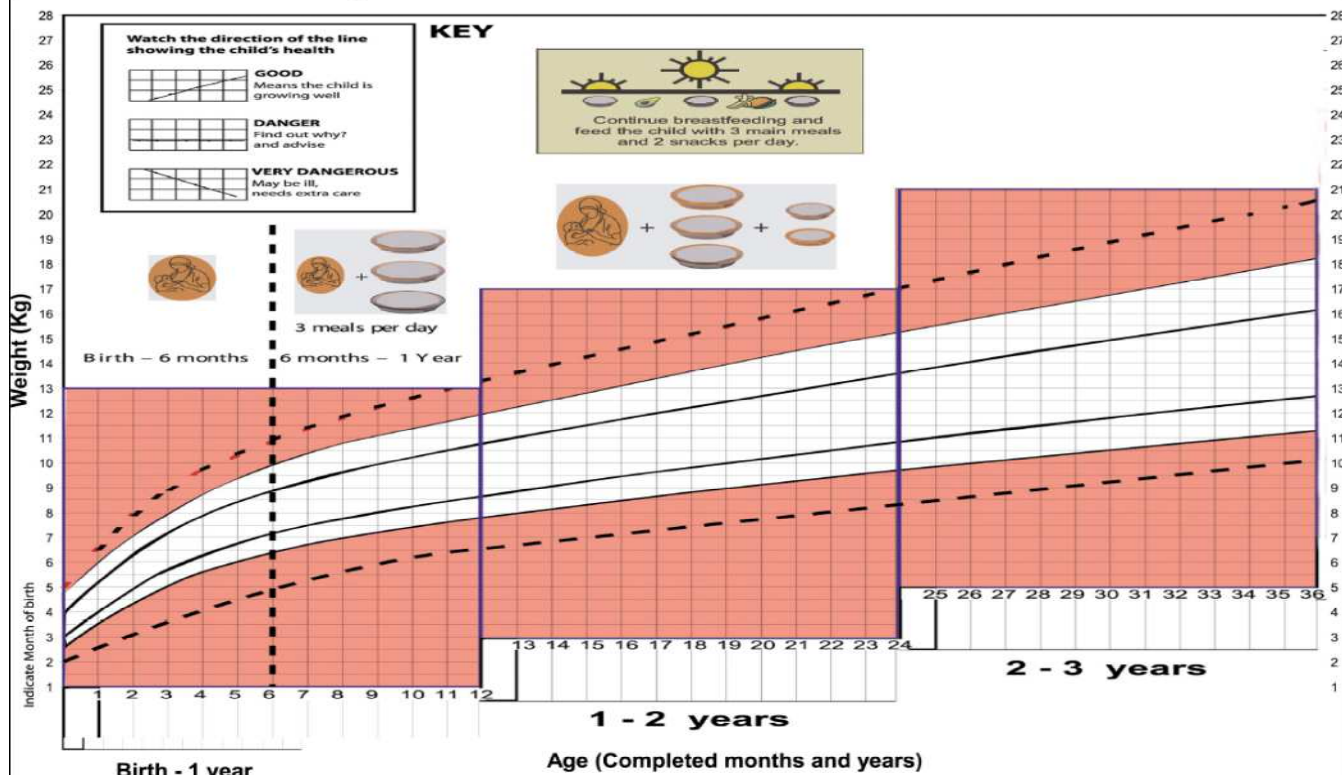
(See page 22 for special care)



±3 Refer for further investigations
±2 to±3 Refer for nutritional counselling

Weight-for-Age GIRLS

(See page 22 for special care)



GROWTH, NUTRITION AND DEVELOPMENT MONITORING

Date	Age (*wks/mths*)	Weight (*kgs*)	Height (*cm*)	Infant Feeding	**Medication** **Indicate dose**			**TB Assessment Outcome**	**Milestones** Normal (N) Delayed (D) Regressed(R)	Next Appointment
					NVP (mls)	CTX (mls/mg)	M/Vit			
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)

Infant Feeding Codes
If Infant < 6 Months
EBF – Exclusive breastfeeding
ERF – Exclusive replacement feeding MF- Mixed feeding
If Infant > 6months
BF– Breastfeeding
NBF – Not breastfeeding

TB Assessment Outcomes
No signs = No signs or symptoms of TB
Suspect = TB referral or sputum sent
Confirmed = Confirmed Sputum (+)
TB Rx =Currently on TB treatment.
INH prophylaxis for TB dispensed?
Not done (ND) = Not assessed this visit

Development Milestones by Age	
Age Ranges	**Milestones**
4-6 Weeks	Social Smile
1-3 Months	Head Holding/ Control
2-3 Months	Turns towards the origin of sound
2-3 Months	Extends hand to grasp a toy
5-9 Months	Sitting
7-13 Months	Standing
12-18 Months	Walking
9-24 Months	Talking

CLINICAL NOTES

Date (*dd/mm/yy*)	**Freehand Clinical Notes**