

CAG Group monitoring Form

Facility Name:

CAG Group Number:

Focal Person Name:

Focal Person Contact Number:

Name of Meeting Place:

Date Completed by CAG Focal Person ___/___/_____

Signature of Focal Person:

To be Completed By CAG Focal Person									To be Completed By Nurse				To be Completed By CAG Member		Comments (include any reason for temporary clinic follow up***)
CAG Member Number	First Name	Surname	ARV regimen	On CTX Y/N	Pregnant (P) or on family planning (FP)	TB symptoms* Y/N	Other "Alert" problems**	ARV Tablets remaining	ARV regimen prescribed	CTX Y/N	VL result	Date VL	Signature of Recipient	Date Drugs Received	
1												___/___/_____		___/___/_____	
2												___/___/_____		___/___/_____	
3												___/___/_____		___/___/_____	
4												___/___/_____		___/___/_____	
5												___/___/_____		___/___/_____	
6												___/___/_____		___/___/_____	
7												___/___/_____		___/___/_____	
8												___/___/_____		___/___/_____	
9												___/___/_____		___/___/_____	
10												___/___/_____		___/___/_____	
11												___/___/_____		___/___/_____	
12												___/___/_____		___/___/_____	
13												___/___/_____		___/___/_____	
14												___/___/_____		___/___/_____	
15												___/___/_____		___/___/_____	

*TB Symptoms: Ask if the member has had a cough for more than 2 weeks. Ask if member is losing weight

**Alert problems: Ask if the member has any ankle swelling, puffiness of the face, breathlessness, diarrhea for more than 2 weeks, severe headache

***Reasons for temporary clinic follow up: 1. Pregnant 2. Mum with exposed baby 3. VL > 1000 and needs Enhanced Adherence 4. New TB diagnosed 5. New OI 6. Significant adherence problem 7. Other

Date Nurse Prescribed for CAG : ___/___/_____

Nurse Signature: