**Kenya ART Distribution Form for Stable Patients**

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| **ART Distribution Form for Stable Patients** |
| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Unique No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of ARV Distribution: DD \_\_\_\_\_\_\_\_\_MM\_\_\_\_\_\_\_\_\_YYYY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ART Refill Model: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Phone No: Treatment Supporter Phone No: |
| ARVs regimen being distributed: Quantity (mths): |
| **Other drugs/supplies being distributed and quantity** |
| ☐ CPT / Dapsone, quantity (mths): ☐ Oral Contraception, quantity (mths): ☐ Condoms (yes/no): |
| ☐ Other: , quantity (days): | ☐ Other: , quantity (days): |
| Name of pharmacist:Signature: | Name of ART distributor:Signature: |
| 1. **Patient review checklist *(if yes to any of the questions below, confirm they have enough ART until they can reach the clinic and refer back to clinic for further evaluation; book appointment and notify clinic)***
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| Any missed doses of ARVs since last clinic visit: ☐Yes ☐NoIf yes, how many missed doses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any current/worsening symptoms:  |
| Fatigue: ☐Yes ☐NoCough: ☐Yes ☐No | Fever: ☐Yes ☐NoRash: ☐Yes ☐No | Nausea/vomiting: ☐Yes ☐NoGenital sore/discharge: ☐Yes ☐No | Diarrhoea: ☐Yes ☐NoOther:  |
| Any new medications prescribed from outside of the HIV clinic: ☐Yes ☐NoIf yes, specify: |
| Family planning method used: ☐Yes ☐No | Pregnancy status: ☐Pregnant ☐Not Pregnant ☐Not Sure |
| Referred to clinic: ☐Yes ☐NoIf yes, appointment date: DD\_\_\_\_\_ MM\_\_\_\_\_ YYYY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature of patient upon receipt of the ART: |