REPUBLIC OF KENYA

MINISTRY OF HEALTH

CLINIC VISIT FORM

Name of County: ______________________ Sub-county: ______________________

Ward: ______________________ Facility Name: ______________________

Date (dd/mm/yyyy): ______/_______/________ MFL Code: ______________________

Implementing Partner: ________________ Type of visit: ☐ Initial ☐ Revisit

Reason for visit: ☐ Asymptomatic ☐ Symptomatic ☐ Quarterly Screening checkup ☐ Follow up

Service delivery Model: ☐ Static ☐ Outreach

GENERAL INFORMATION	
Client Name	
Phone no	
Sex	1 = Male 2 = Female
Date of Birth (DD/MM/YYYY)	Age
KP Type (FSW/MSM/MSW/PWID/PWUD/Transman/Transwoman)	
KP unique identifier code	

SERVICES

	Screened	Screening Results	Treated/Support	Referred
STI	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes	☐ No ☐ Yes, if yes Specify ______________
TB	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes	☐ No ☐ Yes, if yes Specify ______________
Hepatitis B	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes ☐ Vaccination	☐ No ☐ Yes, if yes Specify ______________
Hepatitis C	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes	☐ No ☐ Yes, if yes Specify ______________
Overdose management	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes Received naloxone ☐ Yes ☐ No	☐ No ☐ Yes, if yes Specify ______________
Abscess	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes	☐ No ☐ Yes, if yes Specify ______________

SERVICES				
	Screened	**Screening Results**	**Treated/Support**	**Referred**
Alcohol & drug abuse	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes	☐ No ☐ Yes, If yes Specify ________________
Cervical cancer	☐ No ☐ Yes	☐ Negative ☐ Positive	☐ No ☐ Yes	☐ No ☐ Yes, If yes Specify ________________
PrEP	☐ No ☐ Yes ☐ Ongoing	☐ Eligible ☐ Not eligible	☐ Not Initiated ☐ Initiated	☐ No ☐ Yes, If yes Specify ________________
Violence	☐ No ☐ Yes	☐ No ☐ Yes Types of Violence : ☐ Harassment ☐ Assault/Physical abuse ☐ Illegal arrest ☐ Verbal Abuse ☐ Rape/Sexual assault ☐ Discrimination	☐ Not Supported ☐ Supported	☐ No ☐ Yes, If yes Specify ________________
Risk reduction counselling	☐ No ☐ Yes	☐ Eligible ☐ Not Eligible	☐ Not Supported ☐ Supported	☐ No ☐ Yes Counseling EBI provided specify ________________
Family Planning	☐ No ☐ Yes	☐ Eligible ☐ Not Eligible	☐ Yes (Given method) ☐ No (Not given) ☐ Ongoing	☐ No ☐ Yes, If yes Specify ________________
Mental health	☐ No ☐ Yes	☐ Depression unlikely ☐ Mild depression ☐ Moderate depression ☐ Moderate-severe depression ☐ Severe depression	☐ Not Supported ☐ Supported	☐ No ☐ Yes, If yes Specify ________________

HIV testing Services

Self-reported status	Setting of the last HIV test	Counselled	Tested	Frequency of test	Received results	Testing results	Linked to ART
☐ Positive ☐ Negative ☐ Unknown	☐ Universal HTS ☐ Self- testing ☐ Never tested	☐ Yes ☐ No	☐ Yes ☐ No ☐ Not applicable	☐ Initial ☐ Repeat ☐ Not applicable	☐ Yes ☐ No ☐ Not applicable	☐ Positive ☐ Negative ☐ Inconclusive ☐ Known Positive ☐ Not applicable	☐ Yes Facility linked to... ☐ No ☐ Not applicable

HIV Self-Testing

HIV self-test education/ demonstra-tion	Number of HIV self-test kits given	Self-tested for HIV	Date conducted	Frequency of test	Testing results	Confirmatory HIV test results	Facility name where confirmatory was done	Linked to ART
☐ Yes ☐ No	For self-use________ For distributing to others ___________	☐ Yes ☐ No	Date: _________ mm/yr	☐ Initial ☐ Repeat	☐ Positive ☐ Negative ☐ Inconclusive	☐ Positive ☐ Negative ☐ Not done	☐ On-site ☐ Off-site If off-site: specify ___________ ___________	☐ Yes Facility linked to ___________ ☐ No ☐ Not applicable

HTS counselor name: ____________________________ Signature: _____________ Date: _____________

Care and Treatment

Facility of HIV Care	Initiated on ART this month	Active on ART	Eligible for Viral Load	Viral Load Test Done	Viral Load Results
☐ Provided here	☐ Yes ☐ No	☐ Yes ☐ No If No, Circle appropriate: Defaulted, LTFU	☐ Yes ☐ No	☐ Yes ☐ No	Indicate the copies: ☐ Suppressed ☐ Not Suppressed ☐ Results not yet received
☐ Provided elsewhere Specify:	☐ Yes ☐ No	☐ Yes ☐ No If No, Circle appropriate: Defaulted, LTFU	☐ Yes ☐ No	☐ Yes ☐ No	Indicate the copies: ☐ Suppressed ☐ Not Suppressed ☐ Results not yet received
☐ Referred (For newly referred, linkage not yet confirmed)	☐ Not applicable	☐ Not applicable	☐ Not applicable	☐ Not applicable	☐ Not applicable
☐ Not Applicable					

Other Services:

Condom education/demonstration	☐ Yes	☐ No	
Post Abortal Care provided	☐ Yes	☐ No	☐ Referral

Number of condoms given: Male ________________ Female______________

Number of Lubes given: ________________________

Number of needles and syringes given: ___________

PEP ☐ Yes ☐ No

Type of exposure for PEP : ☐ Rape ☐ Condom burst ☐ Other (specify) ______________________________

Linkage to psychosocial support ☐ Yes ☐ No

Other Ailments/ Clinical Notes:

Next Visit Date (DD/MM/YYYY) : ____

Name and Signature of Clinician : ____