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 : _____