REQUEST FOR THIRD LINE ANTIRETROVIRAL THERAPY

PATIENT DETAILS

Patient First Name			
Patient Surname			
Identity number		Patient number	
Date of Birth	Day/month/year		
Age			
Weight		**Height (children)**	
Gender	M/F		

FACILITY DETAILS

Facility Name	
Authorised Prescriber	
Contact Number	
Email Address	
Date	
Signature of Authorised Prescriber	
Date on which ART was initially started	

Past medication history:

Medication	**Dose**	**Route**	**Interval**	**Duration**	**Discontinuation**	
					Date mm/yy	**Reason**
			24 hourly	**<** 6 Mo 1-5 y > 5y	/	
			24 hourly	< 6 Mo 1-5 y > 5y	/	
			24 hourly	< 6 Mo 1-5 y > 5y	/	
			24 hourly	< 6 Mo 1-5 y > 5y	/	
			24 hourly	< 6 Mo 1-5 y > 5y	/	

Reason for discontinuation codes: SE = Side effect, AL = Allergy, FC = Formulary change, NC = Non adherent

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Children: PMTCT history

Was child breastfed?

Did child receive nevirapine at birth and during breastfeeding?

CD 4 count				**Viral load**	
		Children			
Last 3 CD 4 counts results:		CD4%		*Last 3 VL results:*	
Date:		Date:		Date:	
Date:		Date:		Date:	
Date:		Date:		Date:	
Laboratory Resistance test attached: y/n				Results of Viral Resistance Test	
Most recent available tests: ALT CrCl Neutrophil count					
Concomitant medication and indication Children: Is child able to swallow a tablet? y/n					
For office use only:					
Date received:					
Recommendation: Date:					

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