# ANTIRETROVIRAL (ART) MEDICAL RECORD

*(Revised 2025)*

## 1. Patient Identification Data (Write complete information)

**PHN :** ☐☐☐☐☐☐☐☐☐☐☐☐

**File Number :** ☐☐☐ ☐☐☐☐ (Clinic-code, M/F, XXXX)

**Other nos. :** ☐☐☐ ☐☐☐☐ (Clinic-code, M/F, XXXX)

Name of the Clinic : _____

Date of registration : _____ Age at registration: _____

Phone No : _____ Email: _____

**Following 5 details are filled after checking National Identity Card? Yes ☐ No ☐**

1. 1st letter of 1st name ☐ 2. 1st letter of 2nd name ☐ 3. Sex at birth: Male/ Female

4. Date of Birth : ____/ _____ / _____ 5. District of birth_____

**UIC :** ☐☐☐☐☐☐☐☐☐☐☐☐ **Transgender?** Yes ☐ No ☐

**Marital status** ☐ a. Single/Never Married ☐ b. Currently Married & Living with spouse ☐ c. Living together ☐ d. W/S/D

**Nationality** ☐ a. Sri Lankan ☐ b Foreigner _____(country)

**Date of confirmed HIV +ve test:** _____ **Place:** _____

**Reason for HIV testing (Entry point)**

- ☐ 1. Voluntary Testing
- ☐ 2. STD clinic attendees
- ☐ 3. Provider initiated testing (Asymptomatic)
- ☐ 4. Clinical symptoms suggestive of HIV
- ☐ 5. Referred by NGO
- ☐ 6. Contact screening
- ☐ 7. Blood donor
- ☐ 8. EMTCT
- ☐ 9. Visa screening – local
- ☐ 10. Foreign job screening
- ☐ 11. Screening for legal and insurance purposes
- ☐ 12. Screening before medical / surgical procedures
- ☐ 13. Screening as part of a survey
- ☐ 14. TB
- ☐ 15. Prison
- ☐ 16. Others _____

**Sexual Exposure**

- ☐ a. Sexual Contact with Regular Partner of Opposite Sex
- ☐ b. Sexual Contact with Non-Regular Partner of Opposite Sex
- ☐ c. Sexual Contact with Both Sexes
- ☐ d. Sexual Contact with Person of Same Sex
- ☐ e. No sexual exposures

**History of Drug Use**

☐ 1. None ☐ 2. Previous DU ☐ 3. Current DU. ☐ 2. Previous IDU ☐ 3. Current IDU

**Acquired from mother to child transmission**

☐ a. No ☐ b. Yes ☐ c. Not Known

**Recipient of blood/organ/tissue**

☐ a. No ☐ b. Yes

**Possible ongoing risk factors for transmitting the infection to the others**

☐ a. None ☐ c. Sex Worker ☐ e. Injecting drug user

☐ b. MSM ☐ d. Multiple Sex Partners ☐ f. Not Known

## 2. Information about the partners and family

**HIV status of spouse/regular partner**

☐ a. Positive ☐ b. Negative ☐ c. Not Known ☐ d. Not Applicable

**Risk factors for HIV in spouse/live-in partner**

☐ a. None ☐ b. MSM ☐ c. Sex Worker ☐ d. Multiple Sex Partners

☐ e. Injecting Drug User (now or former) ☐ f. Not Known ☐ g. Not Applicable

| Family member: Relationship | Age | HIV status | ART Y/N | Registered No: if on care |
|---|---|---|---|---|
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## 3. Antiretroviral treatment history

**Was ART received before** ☐ a. Yes ☐ b. No

**If yes, reason for prior ARV** ☐ a. ART (defaulted) ☐ b. PEP ☐ c. PrEP

**ARV and duration/ Other remarks:**

## 4. Clinical and laboratory investigations

| | Date | WHO clinical Stage | Body Mass Index (BMI) | CD4 count | Viral load | Outcome |
|---|---|---|---|---|---|---|
| At the registration | | | | | | |
| At start of ARV (baseline) | | | | | | |
| At 6 months ART | | | | | | |
| At 12 months ART | | | | | | |
| At 24 months ART | | | | | | |
| At 60 months ART | | | | | | |

## 6. Antiretroviral treatment

Treatment started date ___/___ /_____

Age at ART initiation _____ ART regimen_____

**Details on substitution or switching of ARV**

| | Date | New Regimen | Reason |
|---|---|---|---|
| **1st Line** | …. / …. ./……. | | |
| | …. /….. / ……. | | |
| **2nd Line** | …. /….. / ……. | | |
| | …. /….. / ……. | | |
| **3rd Line** | …. / …. / ……. | | |
| | …. /….. / ……. | | |

## 7. Tuberculosis treatment during HIV care

**Outcome of TB screening** (tick)

- ☐ Pulmonary TB
  - ☐ Smear-positive
  - ☐ Smear-negative
- ☐ Extrapulmonary site: _____
- ☐ Latent TB/INAH prophylaxis
- ☐ MDR/XDR/TDR TB
- ☐ Recurrent

**Past history of TB**

☐ Yes ☐ No

Site _____

**TB Regimen** (tick)

- ☐ Category I
- ☐ Category II
- ☐ Other specify:

_____

Date start TB Rx:

___/___/_____

**Registration for TB screening**

District:_____

Health Centre:_____

Number:_____

**TB Treatment outcome:**

- ☐ Cure
- ☐ Rx completed
- ☐ Rx failure
- ☐ Died
- ☐ Default
- ☐ Transfer out

Date: ___/___/_____

## 10. End of follow up

☐ Death Date of death: ___/___/_____

☐ Transferred out Date: ___/___/_____ New Clinic _____

## 5. Other conditions and issues (baseline and during follow up)

- ☐ Acute HBV / Chronic HBV
- ☐ Acute HCV / Chronic HCV
- ☐ DM
- ☐ Dyslipidaemia
- ☐ Ischaemic Heart Disease
- ☐ Renal disease
- ☐ Bone changes
- ☐ Malignancies
- ☐ Hypertension
- ☐ Asthma
- ☐ Early syphilis
- ☐ Gonorrhoea
- ☐ Non gonococcal infection
- ☐ Newly diagnosed HSV
- ☐ Newly diagnosed HPV
- ☐ Other STI _____

Other medical and surgical conditions: _____

_____

Long term medications _____

_____

Drug allergy: _____

| **Contraception** | ☐ **Yes** ☐ **No** ☐ **N/R** | **If yes, Type: -** | | | | |
|---|---|---|---|---|---|---|
| | | Any change in contraception options | | | | |
| | | **Changed to** | | | | |
| | | **Date** | | | | |

**Gynaecological/ Obstetric history**

P_____ C_____

**Last Pap smear** ___/___/_____

Last Menstrual Period: _____

**Pregnant now:** ☐ 1. Yes ☐ 2.No

**on PMTCT Services** ☐ 1.Yes ☐ 2.No

## 8. Vaccination details

| | **Hepatitis B Vaccination** | | **HBsAb levels** | | **Any other vaccinations** | |
|---|---|---|---|---|---|---|
| | **dosage** | **date** | **level** | | | **date** |
| **1st dose** | | | | | | |
| **2nd dose** | | | | | | |
| **3rd dose** | | | | | | |
| **4th dose** | | | | | | |

Remarks:-

## 9. Linkage to NGOs/Care Institutions

| Date | Name of organizations/type* | Purpose** |
|---|---|---|
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