

# HIV PATIENT CARE FLOW SHEET (Adult Female)

NAME OF PATIENT _____			Date of Birth (dd/mm/yyyy) _____	Age _____	Sex _____	PHN _____	Height _____
<b>HIV/AIDS HISTORY</b>						<b>Other Medical Hx / Significant Co-Morbidities</b>	
Date of Initial Diagnosis: (dd/mm/yyyy) _____		AIDS Defining Illness _____		Date of Dx _____		<input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Bone Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Diabetes <input type="checkbox"/> Hematological Dx <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Neurological Dx	
Confirmed Result on File: <input type="checkbox"/> Yes <input type="checkbox"/> No							
Mode of HIV Transmission: <input type="checkbox"/> MSM <input type="checkbox"/> IDU <input type="checkbox"/> Heterosexual <input type="checkbox"/> Vertical <input type="checkbox"/> Other							
CD4 Nadir (Abs, %): Result: _____ Date: (dd/mm/yyyy) _____							
HIV Drug Resistance Test (Genotype) Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No (Test after primary infection or on 1st viral load sample)							
<b>GYNECOLOGICAL HISTORY</b>						<b>Sexual Health History</b>	
First Day of Last Menstrual Period (LPM): _____			Menopause <input type="checkbox"/> Yes <input type="checkbox"/> No			Sexually Active: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Menstrual Cycle Length: Every _____ days <input type="checkbox"/> Regular <input type="checkbox"/> Irregular							
Pregnancy Hx: Number of Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____						Contraception: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnancy Intentions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided						Risk Reduction Provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Substance Use History</b>				<b>Allergies / Intolerances / Drug Reactions</b>			
Smoking: <input type="checkbox"/> Active <input type="checkbox"/> Former <input type="checkbox"/> Never							
Alcohol: <input type="checkbox"/> Active <input type="checkbox"/> Former <input type="checkbox"/> Never							
IDU: <input type="checkbox"/> Active <input type="checkbox"/> Former <input type="checkbox"/> Never							
Marijuana: <input type="checkbox"/> Active <input type="checkbox"/> Former <input type="checkbox"/> Never							
Other: _____							
_____ <input type="checkbox"/> Active <input type="checkbox"/> Former							
_____ <input type="checkbox"/> Active <input type="checkbox"/> Former							
<b>ANTIRETROVIRAL (ART) THERAPY HISTORY</b>							
Antiretroviral Medication		Start Date		Stop Date		Reason for Discontinuation	
<b>HIV Laboratory Testing / Assessment (CD4 &amp; pVL q3-4 months or as indicated)</b>							
	Baseline Date / Result		Date / Result		Date / Result		Date / Result
CD4 Count							
CD4 Fraction							
HIV Plasma Viral Load (pVL)							
Weight							
Blood Pressure							
<b>SCREENING</b> (All at baseline and repeat as necessary)				<b>IMMUNIZATIONS</b> (Determine use of immunization in relation to CD4 count, refer to guidelines)			
Screening		Date		Result			
Anti-HAV						Hep A - #1	
HBs Ag						Hep A - #2	
HBs Ab						Hep A - #3	
HBc Ab						Hep B - #1	
Anti-HCV						Hep B - #2	
Toxoplasmosis (IgG)						Hep B - #3	
Syphilis RPR						Pneumovax	
PPD						Tetanus, diphtheria (Td)	
Chest X-Ray						Influenza	
HLA-B*5701 <sup>a</sup>						All at baseline & repeat once after 5 years	
Pap Smear <sup>b</sup>						Routine boosters q10 yrs	
Colposcopy <sup>c</sup>						All annually	
Mammogram <sup>d</sup>							
		Positive / Negative (circle)				a HLA-B*5701 complete for all at baseline or prior to initiating therapy w/ abacavir b Upon initiation of care, repeat at 6 months. If both normal, continue annually c Complete for abnormal pap d Follow BC Guidelines e Refer to Primary Care Guidelines for specific dosing for Hep B immunizations	

**CONTINUED ON REVERSE...**

**PSYCHOSOCIAL INFORMATION**

Housing Status:

Income Source:

Support Network: (is client connected to a support system?)

**HIV-RELATED REFERRALS**

HIV Specialist Referral

Name:

Counselling / Support Referral

Name:

Other Specialist in HIV Care

Name:

Case Manager

Name:

**SELF-MANAGEMENT** Medication Adherence Symptom / Side-Effect Monitoring Weight Management Preventing Transmission Increased Physical Activity Resource Utilization Balanced Diet Addictions Counselling Smoking Cessation Stress Management Effective Communication with  
Health Care Providers Patient Empowerment/Understanding of HIV  
Disease and Tx