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HOME VISIT ENCOUNTER FORM

Date of Visit:
Patient Name:
Unique ID:
Telephone Number:

Family member:
Name
Age
Sex
Telephone number:
Locator information/physical landmark:

ART status: New/Active/IIT/IIT Returned
Current ART Regimen:
Most recent Viral Load:

Last clinic visit date:

Reason for Home Visit Today:

- Routine for new patient/Pediatric/PMTCT
- IIT Returned
- Suspected Treatment Failure patient
- Other : Specify____ (as recommended by MDT/Clinician)

With Patient's / care giver's consent document observations using the following checklist

	Areas to Assess/Observe during Home Visit	Y/N	Comments
1.	Clients general living condition: Is it generally clean and well ventilated?		
2.	Is the patient independent in the activities of daily living (e.g. feeding, grooming, toileting)?		
3	Meeting their basic needs e.g. clothing, shelter, food ,school (for children)?		

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4	Does the client/caregiver engage in other social activities/habits that could serve as barriers to adherence?		
5	Has the client ever stopped taking medication because of their faith or other cultural beliefs ?		
6	Is the client suffering from any stressful situation or significant loss/grief		
7	Is drug use or alcohol interfering with the patient's adherence to their medication?		
8	*Where applicable,* Is child or adolescent performing well at school?		
9	Is the client (child's caregiver) facing any form of Gender Based Violence?		
10	Has the client disclosed their HIV status to other household members? If Yes indicate Who_____ If No, discuss plans		
	Where applicable - Has aPNS been initiated ?		
11	**Medication adherence:** Does client store medication well according to guidance given at the clinic		
	Is client taking medications correctly?		
	Is the patient having any side-effects from the medications? If Yes specify		
	Are the side effects making it difficult for the patient to adhere to medication		
	Does the patient often have to travel away from home? Does the patient's occupation pose a barrier to adherence to medication (stigma, fear of discrimination, time conflicts)?		
	Does patient have to use reminder systems ? If yes Specify		
	Has the client been able to fit the taking of medication into their daily routine?		

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	Does taking drugs every other day bother the client?		
12	**Social support:** Does the patient receive social support from household members? Eg. With childcare, school visitations etc		
	Is the patient linked to other support services (e.g. support group, other CBO, spiritual, legal or nutritional)? If Yes, specify		
	Are any other members of the community aware of the patient's HIV status? If Yes, Indicate Who_____		
	Does the patient receive social support from members of the community? Eg. Bursary, stipends, etc		
14	Screen for IPV/GBV		
15	**Preventive services** Access to HIV transmission preventive services ? Has access to FP services - *where applicable ?* Accessed CX Ca screening - *where applicable ?* Screened for TB (Cough, weight loss, night sweats) ?		

Any other observation not captured above :

_____

_____

_____

Summary:

Treatment Motivators:

_____

_____

_____

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Barriers to treatment adherence

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_____

_____

_____

Adherence support/Action plan

_____

_____

_____

_____

Confirm Return date to clinic: DD/MM/YY

Make another home visit? Y/N, specify date:

Case manager/provider initials_____