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| MEDICALLY ASSISTED THERAPY  CLINICAL ENCOUNTER FORM | FORM 3A |

**VER.APRIL 2023 FORM 3A**

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| **Facility Name ……………….MFL CODE………………**  **County….................................** | | **Sub County…................................** | | |  | | |
| **Enrolment Date dd/mm/yyyy)…..............** | | **Time…...........................................** | | |  | | |
| **(BIODATA)** **INDUCTION** **REINDUCTION** | | | | | | | |
|  |  |  |  |  |  |  |  |
| **PART A: CLIENT PROFILE** | |  |  |  |  |  |  |
| **1** | Client Name…..............................................(biodata) | | | Nickname….................................... | | | |
| **2** | MAT/Unique ID Number…....................................................................................................................... | | | | | | |
| **3** | Sex | | Male Female Transgender Male Transgender Female | | | | |
| **4** | Presenting complaints |  | | | | | |
| **5** | **DRUG USE HISTORY** | | | | | | |
| **Type of Drug** | | **Age first use drug** | **Duration of use (years)** | **Frequency of use in last 30 days**  (Never, Once or Twice, Weekly, Almost Daily, Daily) | **Quantity used regularly**  (within past 30 days) | **Usual route of administration**  (Oral Nasal Smoking Injection) | **Date &time last used**  (within past 30 days) |
| a | Heroin |  |  |  |  |  |  |
| b | Cannabis Sativa |  |  |  |  |  |  |
| c | Tobacco |  |  |  |  |  |  |
| d | Benzodiazepines |  |  |  |  |  |  |
| e | Alcohol |  |  |  |  |  |  |
| f | Amphetamine |  |  |  |  |  |  |
| g | Cocaine |  |  |  |  |  |  |
| h | Miraa |  |  |  |  |  |  |
| i | Glue |  |  |  |  |  |  |
| j | Barbiturates |  |  |  |  |  |  |
| k | Phencyclidine |  |  |  |  |  |  |
| l | Other |  |  |  |  |  |  |
| **6** | **HEROIN INJECTING DRUG USE HISTORY** | | | |  | | |
| a | History of injecting drug use | | | | Yes No | | |
| b | Reasons for shifting to injecting drug use | | | | Peer Pressure Feel High  Financial   Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| c | Ever injected yourself with blood of someone who just injected drugs (blood sharing practise known as 'flash blood"?) | | | | Yes No | | |
| d | Have you ever shared needles and syringes or other injecting equipment? | | | | Yes No | | |
| e | Ever had any complications of injecting (abscesses, wound/ulcer, blocked veins, gangrene) | | | | Yes No | | |
| f | Ever experienced any incidents of drug overdose? | | | | Yes No | | |

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| 7. |  | | |  |
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| **8.** | **VITAL SIGNS** | | |  |
|  | a. Pulse |  | |
|  | b. Oxygen saturation |  | |
|  | c. Blood pressure |  | |
|  | d. Temperature |  | |
|  | e. Respiratory rate |  | |
|  | f. Height |  | |
|  | g. Weight |  | |
|  | h. BMI | Interpretation:  <18.5 –Underweight 18.5‐24.9 – Normal 25‐29.9 – Overweight >30 ‐ Obesity | |

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| **9. CLINICAL OPIATE WITHDRAWAL SCALE (COWS)** | Time 1  ……………. | Time 2  …………….. | Time 3  ………………. | Time 4  ………………... |
| **Resting Pulse Rate**: (record beats per minute)  *Measured after patient is sitting or lying for one minute*  0 pulse rate 80 or below  1 pulse rate 81‐100  2 pulse rate 101‐120  4 pulse rate greater than 120 |  |  |  |  |
| **Sweating:** *over past ½ hour not accounted for by room temperature or patient activity.*   1. no report of chills or flushing 2. subjective report of chills or flushing 3. flushed or observable moistness on face 4. beads of sweat on brow or face 5. sweat streaming off face |  |  |  |  |
| **Restlessness** *Observation during assessmen*t  0 able to sit still  1 reports difficulty sitting still, but is able to do so  3 frequent shifting or extraneous movements of legs/arms  5 Unable to sit still for more than a few seconds |  |  |  |  |
| **Pupil size**  0 pupils pinned or normal size for room light  1 pupils possibly larger than normal for room light  2 pupils moderately dilated  5 pupils so dilated that only the rim of the iris is visible |  |  |  |  |
| **Bone or Joint aches***If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*  0 not present  1 mild diffuse discomfort  2 patient reports severe diffuse aching of joints/ muscles  4 patient is rubbing joints or muscles and is unable to sit still because of discomfort |  |  |  |  |
| **Runny nose or tearing***Not accounted for by cold symptoms or allergies*  0 not present  1 nasal stuffiness or unusually moist eyes  2 nose running or tearing  4 nose constantly running or tears streaming down cheeks |  |  |  |  |
| **GI Upset**: *over last ½ hour*  0 no GI symptoms  1 stomach cramps  2 nausea or loose stool  3 vomiting or diarrhea  5 Multiple episodes of diarrhea or vomiting |  |  |  |  |
| **Tremor** *observation of outstretched hands*  0 No tremor  1 tremor can be felt, but not observed  2 slight tremor observable  4 gross tremor or muscle twitching |  |  |  |  |
| **Yawning** *Observation during assessment*  0 no yawning  1 yawning once or twice during assessment  2 yawning three or more times during assessment  4 yawning several times/minute |  |  |  |  |
| **Anxiety or Irritability**  0 none  1 patient reports increasing irritability or anxiousness  2 patient obviously irritable anxious  4 patient so irritable or anxious that participation in the assessment is difficult |  |  |  |  |
| **Gooseflesh skin**  0 skin is smooth  3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection |  |  |  |  |
| **Total scores** |  |  |  |  |
| **Scale:** 1. 5‐12 = mild;   1. 13‐24 = moderate; 2. 25‐36 = moderately severe; 3. more than 36 = severe withdrawal | 1.  2.  3.  4. | 1.  2.  3.  4. | 1.  2.  3.  4. | 1.  2.  3.  4. |

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| **CLINICAL OPIATE WITHDRAWAL SCALE (COWS)** | Time 1  ……………. | Time 2  …………….. | Time 3  ………………. | Time 4  ………………... |
| Name of Service Provider:  …………………………………………………………………………………………… | Signature Date | | | |

**PART B. CLINICAL ASSESSMENT**

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| **10.** | **PERSONAL MEDICAL HISTORY** | | | | | | |
|  | **Have you ever been diagnosed with any of the following illnesses?** | | | | | | **If so, current medication and dose for illness** |
|  | a. Asthma | | | Yes No | | |  |
|  | b. Heart disease | | | Yes No | | |  |
|  | c. Tuberculosis | | | Yes No | | |  |
|  | d. Liver disease | | | Yes No | | |  |
|  | e. STDs (syphilis, chlamydia, gonorrhoea, etc.) | | | Yes No | | |  |
|  | f. Accidents or surgery | | | Yes No | | |  |
|  | g. HIV | | | Yes No | | | **Date of HIV diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Complete HIV Intake Form (3D)*  **H. Facility of Care***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
|  | h. Hypertension | | | Yes No | | |  |
|  | 1. Hepatitis B | | | Yes No | | |  |
|  | j. Hepatitis C | | | Yes No | | |  |
|  | k. Diabetes | | | Yes No | | |  |
|  | m. Any other medical problems or medications: | | |  | | | |
|  | n. Do you have any allergies? | | | Sulphur Penicillin None Other(Specify) | | | |
| **11.** | **REPRODUCTIVE HEALTH HISTORY** | | | | | | |
|  | a. Are you using any contraception? Yes No | | | |  | | |
|  | b. If YES, which method are you using? (Mark all responses mentioned) add checkbox | 🞏Male condom 🞏Female condom  🞏Injectables 🞏IUD Implants  🞏Lactational Amenorrhea 🞏Foam/jelly Withdrawal .  🞏Rhythm method 🞏 Abstain  🞏Emergency contraception 🞏Female sterilization  🞏Male sterilization 🞏 Pill 🞏 None | | | | | |
|  | c. Last menstrual period? If Female(dd/mm/yyyy) |  | | | | | |
|  |  |  | | | | | |
| **12.** | **FAMILY MEDICAL HISTORY** | | | | | | |
|  | **Is there anyone in your family with any of**  **these illnesses?** | |  | | | **If yes, please specify which family member**  **and the type of illness** | |
|  | a. Mental illness | | Yes No | | |  | |
|  | b. Drug dependence | | Yes No | | |  | |
|  | c. TB | | Yes No | | |  | |
|  |  | |  | | |  | |
|  | e. Others (specify) | | Yes No | | |  | |
| **13.** | **MENTAL AND PSYCHOLOGICAL HISTORY** | | | | | | |
|  | a. Depression | | Yes No | | |  | |
|  | b. Anxiety | | Yes No | | |  | |
|  | c. Sleep Disorder | | Yes No | | |  | |
|  |  | |  | | |  | |
|  | e. Psychosis | | Yes No | | |  | |
|  | f. PTSD | | Yes No | | |  | |

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|  | i. Other (Specify) | | Yes No |  |
| **14.** | **PHYSICAL EXAMINATION** | | | |
|  | a. General Appearance, signs of intoxication/ overdose? | **Yes No** | | |
|  | b. Pallor |  | | |
|  | c. Jaundice |  | | |
|  | d. Cyanosis |  | | |
|  | e. Dehydration |  | | |
|  | f. Nutritional Status |  | | |
|  | g. Lymphadenopathy |  | | |
|  | h. Oedema |  | | |
| **15.** | **SYSTEMIC EXAMINATION** | | | |
|  | a. Cardiovascular system |  | | |
|  | b. Respiratory system |  | | |
|  | c. Gastrointestinal system |  | | |
|  | d. Genitourinary system |  | | |
|  | e. Central and peripheral nervous  system |  | | |
|  | f. Skin and musculoskeletal system Evidence of injecting drugs? | **Yes No**  **If Yes: i**njection marks inflammation cellulitis abscess | | |
| **16.** | **MENTAL STATUS EXAMINATION** | | | |
|  | a. Appearance | □normal grooming, well kempt □unkempt, dirty  other (specify) | | |
|  | b. Attitude and behavior | □Calm & Cooperative □restless □uncooperative  □no unusual movements □mannerisms □violent other (specify) | | |
|  | c. Speech | □coherent □incoherent □normal tone, rate, content, volume  □pressured □poverty of speech other (specify) | | |
|  | d. Mood | □euthymic □irritable □depressed □elevated  other (specify) | | |
|  | e. Affect | □appropriate/mood congruent □tearful, sad □elated | | |
| □labile □flat/blunted | | Other (Specify) |
|  | f. Thought Process Thought Content | □ logical □illogical □pressured □disorganized | | |
| □normal □delusions □suicidal □phobias □obsessions □ Homicidal | | |
|  | g. Perception  Hallucinations  Illusions | 🞏Auditory 🞏Visual 🞏Olfactory 🞏Tactile 🞏Gustatory🞏Absent 🞏Present 🞏Absent | | |
|  | h. Attention and Concentration | 🞏Good 🞏Fair  Poor | | |
|  | i. Orientation  Time  Place  Person | Present Absent  Present Absent  Present Absent | | |

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| --- | --- | --- | --- |
|  | j. Memory  Immediate recall Recent  Remote | 🞏Intact 🞏Impaired  🞏Intact 🞏Impaired  🞏Intact 🞏Impaired | |
|  | k. Judgment | 🞏Good 🞏Fair 🞏Poor | |
|  | l. Insight | 🞏Present 🞏Absent | |
| **17.** | **OTHER NOTABLE PHYSICAL EXAMINATION FINDINGS** | | |
|  |  | | |
| **18.** | **DIAGNOSIS** | | |
|  | **a. Opioid Use Disorder** | | **injecting**  **non –injecting** |
|  | **b. Other Substance Use Disorder** | |  |
|  | **c. Mental Health Disorder** | |  |
| **19.** | **TREATMENT PLAN**  For eligible clients with  1) No contraindication to methadone/Buprenorphine, 2) Signed consent form and 3) Able to make daily visits | | |
|  | a. **Methadone/Buprenorphine Induction**  (Initial dose and schedule for review) | | ……………………………………………………………………………………………  ……………………………………………………………………………………………  …………………………………………………………………………………………… |
|  | b. **Symptomatic treatment for heroin side effects**  (nausea, headache, disturbed sleep, sweating) | | ……………………………………………………………………………………………  ……………………………………………………………………………………………  …………………………………………………………………………………………… |
|  | **c. Management of identified co‐morbidities** (Mental disorders, HIV, Hepatitis B, Hepatitis C, TB, STI, etc.) | | ……………………………………………………………………………………………  ……………………………………………………………………………………………  …………………………………………………………………………………………… |

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|  | **d. Psychosocial support**   * Individual Counseling * Group Counseling * Recovery Support * Group Other (Specify) | ……………………………………………………………………………………………  ……………………………………………………………………………………………  …………………………………………………………………………………………… | |
|  | **e. Referrals and Linkages**   * HIV care and treatment * Psychiatric care * Surgical care * Consultant Physician care * Sexual reproductive health services * Maternal and Child care services * TB treatment services (DOTS) * Drug treatment facilities: Drop in Centres, Rehabilitation | | ……………………………………………………………………………  ……………………………………………………………………………  ……………………………………………………………………………  ……………………………………………………………………………  ……………………………………………………………………………  …………………………………………………………………………… |
| Centres   * Nutritional support * Support groups: Legal aid, PLHA or PWUD network, Self‐help | | …………………………………………………………………………… |
| Groups, Women’s organizations, Youth Groups   * Welfare agencies: food, shelter, clothes, IGAs for PWID * Others: police, anti‐narcotics bureau; community groups; | | ……………………………………………………………………………  …………………………………………………………………………… |
| religious groups; opinion leaders; private companies; etc. | |  |
| Name of Service Provider:  …………………………………………………………………………………………… | | | Signature Date |