|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FORM 3C - MEDICALLY ASSISTED THERAPY - PATIENT TREATMENT CARD VER. APRIL 2023** | | | | | | | | | | |
| **Clinical follow up Visits** | | | | | | | | | | |
| **Patient MAT Unique Identification Number** |  | **DDMMYYY** | **DDMMYY** | **DDMMYY** | **DDMMYYY** | **DDMMYY** | **DDMMYY** | **DDMMYYY** | **DDMMYY** | **DDMMYY** |
| **Date of consultation** |  |  |  |  |  |  |  |  |  |  |
| **Date Started on MAT** |  |  |  |  |  |  |  |  |  |  |
| **Vital signs** | Height/Weight (BMI) |  |  |  |  |  |  |  |  |  |
| BP |  |  |  |  |  |  |  |  |  |
| Pulse Rate |  |  |  |  |  |  |  |  |  |
| Temperature |  |  |  |  |  |  |  |  |  |
|  | RR/SP02 |  |  |  |  |  |  |  |  |  |
|  | Alcohol Breathalyzer results |  |  |  |  |  |  |  |  |  |
| **Methadone/Buprenorphine maintenance** | Current MTD/Buprenorphine dose |  |  |  |  |  |  |  |  |  |
| Complaints |  |  |  |  |  |  |  |  |  |
| Signs of overdose/over medication |  |  |  |  |  |  |  |  |  |
| Urine drug test results |  |  |  |  |  |  |  |  |  |
| ECG results |  |  |  |  |  |  |  |  |  |
| Days missed doses |  |  |  |  |  |  |  |  |  |
| COWS Score |  |  |  |  |  |  |  |  |  |
| New MTD/Buprenorphine dose |  |  |  |  |  |  |  |  |  |
| Reason for Dose Adjustment |  |  |  |  |  |  |  |  |  |
| **Treatment for MTD/Buprenorphine Side effects** |  |  |  |  |  |  |  |  |  |  |
| **Management of identified co-morbidities** | Mental Health disorder Treatment |  |  |  |  |  |  |  |  |  |
| ART Regimen (All HIV +ve clients) |  |  |  |  |  |  |  |  |  |
| Viral Load Results |  |  |  |  |  |  |  |  |  |
| PrEP/PEP |  |  |  |  |  |  |  |  |  |
| TB Screening/Treatment Regimen |  |  |  |  |  |  |  |  |  |
| Hepatitis B – Regimen |  |  |  |  |  |  |  |  |  |
| Hepatitis C – Regimen |  |  |  |  |  |  |  |  |  |
| STI Treatment |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |
| **Reproductive Health Services** | Pregnant (Yes/No/NA) |  |  |  |  |  |  |  |  |  |
| LMP |  |  |  |  |  |  |  |  |  |
| EDD |  |  |  |  |  |  |  |  |  |
| Cervical cancer screening (Y/N) |  |  |  |  |  |  |  |  |  |
| On FP (Y/N) |  |  |  |  |  |  |  |  |  |
| FP Method |  |  |  |  |  |  |  |  |  |
| GBV Screening results |  |  |  |  |  |  |  |  |  |
| **Referral and Linkages** | Psychosocial Support |  |  |  |  |  |  |  |  |  |
| Psychiatric Support |  |  |  |  |  |  |  |  |  |
| Nutritional Support |  |  |  |  |  |  |  |  |  |
| Vaccination Service |  |  |  |  |  |  |  |  |  |
| Sexual and Reproductive Health |  |  |  |  |  |  |  |  |  |
| Radiology service |  |  |  |  |  |  |  |  |  |
| Laboratory Service |  |  |  |  |  |  |  |  |  |
| Legal/Paralegal services |  |  |  |  |  |  |  |  |  |
| Social Protection |  |  |  |  |  |  |  |  |  |
| GBV Services |  |  |  |  |  |  |  |  |  |
| Others |  |  |  |  |  |  |  |  |  |
| **Date of Next Visit** |  |  |  |  |  |  |  |  |  |  |
| **Clinician Name** |  |  |  |  |  |  |  |  |  |  |
| **Signature** |  |  |  |  |  |  |  |  |  |  |

\*\*(**Below 0.02 full dose, 0.02 - 0.04 half dose, >0.04 withhold dose)**