HIV PEP Follow-up Visits Nursing Documentation

CHECK 'YES' OR 'NO'

IF TASK NOT COMPLETED AT VISIT, EXPLAIN IN NOTES

	1st Follow-up (Day 2-4)		2nd Follow-up (Week 1)*		3rd Follow-up (Week 2)		4th Follow-up (Week 3)		5th Follow-up (Week 4)*	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Date of Visit (dd / mm / yyyy)	/ /		/ /		/ /		/ /		/ /	
Name of Examiner	_____		_____		_____		_____		_____	
Able to contact client since last visit?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reviewed the risk of HIV transmission	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Discussed management of the HIV PEP regimen	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Discussed & documented side effects experienced	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Muscle weakness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Painful neuropathy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fever	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergic reaction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rash (mucocutaneous)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify):	_____		_____		_____		_____		_____	
Reviewed self care management	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Discussed HIV testing (IF not done at Initial Visit)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bloodwork taken to assess drug toxicity	N/A		N/A		☐	☐	N/A		N/A	
Reviewed blood results	☐	☐	N/A		N/A		☐	☐	N/A	
Specify abnormal result(s)	_____		N/A		N/A		_____		N/A	
Considered consultation with MD or HIV Expert	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MD consultation or referral required?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
IF Yes, date of consultation/referral (dd / mm / yyyy)	/ /		/ /		/ /		/ /		/ /	
HIV Expert consultation or referral required?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
IF Yes, date of consultation/referral (dd / mm / yyyy)	/ /		/ /		/ /		/ /		/ /	
Client continuing to take HIV PEP?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIV PEP drugs provided	☐	☐	N/A		☐	☐	☐	☐	N/A	
Reminded client to have follow-up HIV testing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

* 2nd Follow-up (Week 1) and 5th Follow-up (Week 4) can be completed either in-person, or by phone

NOTES: