MEDECINS SANS FRONTIERES

MSF in-patient care form

NDH admission number:		MSF ID number:
Patient's name:		
Gender: ☐ male ☐ female	Age:	Nationality:
Address:		Health centre of origin: ☐ referred by HCW ☐ self-referral

Reason for filling the form: ☐ **HIV** ☐ **TB** ☐ **Death**

HIV status:	TB status:	Outcome:
☐ positive known prior to admission ☐ diagnosed whilst on the ward ☐ negative ☐ unknown Last HTC date: : ____/____/_______	☐ positive ☐ negative	☐ discharged home ☐ death ☐ absconded ☐ referred Date of Outcome: ____/____/_______

ADMISSION

Date of Admission: ____/____/_______ Time of admission: : _____________

Presenting complaints (*tick all that apply*):

☐ Cough	☐ Vomiting	☐ Confusion	☐ Skin lesions
☐ Fever	☐ Diarrhoea	☐ Convulsion	☐ Other
☐ Weight loss	☐ Abdominal pain	☐ Headache	Specify other: ___________________
☐ Night sweats	☐ Jaundice	☐ Chest pain	___________________
☐ Shortness of breath	☐ Dysphagia	☐ Heart palpitations	

How long had these complaints been present? (*consider the symptom with the longest duration*) _________ days

Danger signs on admission (*tick all that apply*. Write in NA if not available in the admission note):

☐ fever ≥ 39°C
☐ tachycardia (HR ≥ 120 bpm)
☐ tachypnea (RR ≥ 30 ipm)
☐ hypotension (BP < 90 mmHg)
☐ non-ambulatory
☐ moderate/severe dehydration
☐ altered mental state or any other abnormal neurology, including headache, seizures

EXAMS AND INVESTIGATIONS

AFB smear

Date (first sample collected): ____/____/_______

AFB result (*positive if +++/++/+/scanty*):

Sputum: ☐ Positive ☐ Negative ☐ Not done

Non sputum: ☐ Positive ☐ Negative ☐ Not done

Specimen type (*tick all that apply*):

☐ Sputum ☐ CSF ☐ Lymph node
☐ Pus ☐ Urine ☐ Ascites ☐ Pleural fluid

GeneXpert

Date (first sample collected): ____/____/_______

GeneXpert result:

Sputum: ☐ Positive ☐ Negative ☐ Rif-resistance ☐ Not done

Non sputum: ☐ Positive ☐ Negative ☐ Rif-resistance ☐ Not done

Specimen type (*tick all that apply*):

☐ Sputum ☐ CSF ☐ Lymph node
☐ Pus ☐ Urine ☐ Ascites ☐ Pleural fluid

Urine LAM Date: : ____/____/_______ ☐ *Positive* ☐ *Negative* ☐ *Not Done*

Chest X-ray	____ Not done	____ Done	Date ____/____/_______ ☐ normal ☐ abnormal suggestive for active TB ☐ abnormal suggestive for inactive TB ☐ abnormal not suggestive for TB

If CXR findings suggestive for active TB: *(tick all that apply)*: ☐ Infiltrate or consolidation ☐ Any cavitary lesion ☐ Nodule with poorly defined margins ☐ Pleural effusion ☐ Hilar/mediastinal lymphadenopathy ☐ Miliary aspect	If CXR findings suggestive for inactive TB *(tick all that apply)*: ☐ Discrete fibrotic scar or linear opacity, with/without volume loss or retraction ☐ Lobe bronchiectasis ☐ Discrete nodule(s) without calcification, with/without volume loss or retraction

Ultrasound scan	____ Not done	____ Done	Date ____/____/_______ ☐ suggestive ☐ not suggestive If suggestive: ☐ peritoneal fluid ☐ upper abdominal lymph nodes ☐ pericardial fluid ☐ splenomegaly ☐ pleural fluid ☐ hepatic/liver abscess
Ophthalmoscope	____ Not done	____ Done	Date ____/____/_______ ☐ Normal ☐Retinitis ☐ Abnormal without retinitis

Blood Tests			
	Date ordered	Date of results	Result / remarks
( ) CD4 count			
( ) Viral load			
( ) CrAg			
( ) MRDT			
( ) HBsAg			
( ) anti HCV			
( ) VDRL			
( ) Syphilis RT			
( ) FBC			Hb: WBC: Platelets:
( ) Creatinine			
( ) LFTs			ALT: ALP: Bilirubins: (direct bilirubin:) albumin:

If **lumbar puncture** was performed (date: ____/____/_______), please fill in the following results:

	Date of results	Results / remarks
( ) white cell count		No of cells: PMN: Lymphocytes:
( ) protein		
( ) glucose		
( ) CrAg		
( ) VDRL		

DIAGNOSIS AND COMORBIDITIES

Date of diagnosis: ____/____/_______

Main diagnosis (*tick all that apply*):

- ☐ Pulmonary TB
- ☐ Extrapulmonary TB
- ☐ Crypto meningitis
- ☐ Bacterial meningitis
- ☐ Pneumocystis pneumonia (PCP)
- ☐ Malaria
- ☐ Other, Specify:
- ☐ Immune reconstitution inflammatory syndrome (IRIS)
- ☐ Oesophageal candidiasis
- ☐ Chronic diarrhoea
- ☐ Pneumonia
- ☐ Sepsis/Bacteremia
- ☐ Cytomegalovirus (CMV)
- ☐ Kaposi sarcoma
- ☐ Toxoplasmosis
- ☐ Herpes simplex
- ☐ Chronic anaemia
- ☐ Hepatitis

TREATMENT AND PROPHYLAXIS

Treatment prescribed (*report only antibiotics, antifungals, antivirals and steroids*):

Drug prescribed	**Dosage**	**Start date**	**Finish date**

HIV SESSION

Date of HIV diagnosis: ____/____/_______ ☐ Unknown

ART: ☐ naïve

☐ ART experienced ART number: ________________

Date of last ART visit: ____/____/_______

Regularly attending to visits during last year: ☐ Yes ☐ No

Date of last VL: ____/____/_______

Result (*or NA if not available*): ______________ copies

ART start date: ____/____/_______

ART regimen: ____________________

If 2nd line, start date ____/____/_______

2nd line regimen: __________________

TB SESSION

Date of TB diagnosis: ____/____/_______

Diagnostic criteria (*mark all that apply*):

- ☐ Clinical diagnosis
- ☐ Microbiological confirmation

TB diagnosis: ☐ Pulmonary

☐ Extrapulmonary,

(specify the localization, tick all that apply):

- ☐ Lymphatic
- ☐ Pleural
- ☐ Genitourinary
- ☐ Bone/joints
- ☐ Meningitis
- ☐ Pericardial
- ☐ Abdominal/peritoneal
- ☐ Cutaneous

TB case definition:

- ☐ New case
- ☐ Relapse
- ☐ Treatment after failure
- ☐ Treatment after default
- ☐ Previous TB treatment status unknown
- ☐ Other

TB treatment prescribed:

- ☐ No
- ☐ Yes, regimen: _________________________

Date of TB treatment start: ____/____/_______

Contacts known to have TB? ☐ yes ☐ no ☐ unknown If yes, is the contact a patient with DR-TB? ☐ yes ☐ not

DEATH SESSION
Date ____/____/_______ and time __________ of death Cause of death: ____

COMMENTS/REMARKS
Record relevant comments (laboratory, clinical management, etc)

Date: ____/____/_______

Clinician: ______________________________ Nurse: ______________________________

Signed: ______________________________