

 health Department of Health REPUBLIC OF SOUTH AFRICA			
First name		Folder #	
Surname		Phone #	
DOB	dd / mm / yy	Gender:	M / F / TG
ID Number		Date of visit:	dd / mm / yy
Address 			
Instructions: Please use the form to document the circumstances/factors/situations pertaining to the seroconversion of the PrEP client. The available fields should be completed with the relevant information available at the time of reporting. Please complete and affix a copy of the PrEP clinical form and/or any relevant documentation.			
PrEP drugs exposure before positive HIV test			
PrEP start date: dd / mm / yy		Date of HIV+ Test: dd / mm / yy	
Drug name (s): _____			
PrEP History			
1. At the time of the positive test result, is the client still on PrEP?	<input type="checkbox"/> Y Client is still on PrEP Which PrEP method was used? <input type="checkbox"/> Oral <input type="checkbox"/> DVR <input type="checkbox"/> CAB LA <input type="checkbox"/> Len		
	<input type="checkbox"/> N Client is still on PrEP (Specify date when the last PrEP dose was taken): dd / mm / yy _____		
2.1 In the last 3 months, has the client been taking/using oral PrEP effectively? 2.2 Has the client taken a lenacapavir or cabotegravir injections as per schedule?	<div style="display: flex; justify-content: space-around;"> <div> Oral PrEP <input type="checkbox"/> 0 Never missed a dose <input type="checkbox"/> 1 Missed doses 1-6day <input type="checkbox"/> 2 Missed doses >7 Day </div> <div> Lenacapavir <input type="checkbox"/> 0 On scheduled date <input type="checkbox"/> 1 Missed injection 1-14 days <input type="checkbox"/> 2 Missed injection >14 Days </div> <div> CAB LA <input type="checkbox"/> 0 On scheduled date <input type="checkbox"/> 1 Missed injection 1-28 days <input type="checkbox"/> 2 Missed injection > 1 month </div> <div> Ring <input type="checkbox"/> 0 Ring inserted on schedule <input type="checkbox"/> 1 No ring 1-28 days <input type="checkbox"/> 2 No Ring > 1 month </div> </div>		
	3. What is the clients partner/s HIV status?		
	<input type="checkbox"/> 1 Partner/s is HIV negative <input type="checkbox"/> 3 Don't know partner/s HIV status <input type="checkbox"/> 2 Partner/s is HIV positive		
	4. Did client use a condom with partner/s?		
<input type="checkbox"/> 1 Always <input type="checkbox"/> 2 Sometimes <input type="checkbox"/> 3 Never			
5. Additional comments on circumstances relating to the seroconversion:			
Resistance Testing Results			
Date	Comments:		
dd / mm / yy			
dd / mm / yy			
dd / mm / yy			
Relevant medical history			