NIGERIAQUAL
ADULT ART AUDIT CHART

A. FACILITY DETAILS

FACILITY NAME: _____

STATE: _____ LGA: _____

IMPLEMENTING PARTNER: _____

NAME OF ASSESSOR: _____

Date of Assessment (dd/mm/yyyy): __ / __ / ____

Review Period __ / __ / ____ To __ / __ / ____

B. LEVEL (Check one)

☐ Primary Health Centre ☐ Secondary Hospital

Tertiary Hospital
☐ Federal med. Centre ☐ Specialist Hospital
☐ Teaching Hospital

Ownership ☐ Public ☐ Faith-based ☐ Private

C. PATIENT DEMOGRAPHICS

Patient ID __ - __ - ____ Hospital No. ____ RNL Serial No. ____ Gender ☐ Male ☐ Female

Last name: _____ Date of Birth: __ / __ / ____

First name: _____ Age: __

Has the patient had a clinical visit 6 months prior to review period? ☐ Yes ☐ No

(If No, Please discard form)

Hospital admission during review period: ☐ Yes ☐ No

Date of Enrollment: __ / __ / ____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation ☐ Unemployed ☐ Employed ☐ Student ☐ Retired

Education ☐ None ☐ Quranic ☐ Primary ☐ Junior Secondary ☐ Senior Secondary ☐ Post Secondary

Ward/Village/Town of residence: _____

LGA of residence: _____ State of residence: _____

State of Origin: _____ Tribe: _____

D. BASELINE PARAMETERS *(Initial)*

CD4 Count: ____ CD4 count date (dd/mm/yyyy) __ / __ / __ ☐ CD4 value not recorded

Weight (kg): ____.__ Weight date (dd/mm/yyyy) __ / __ / __ ☐ Weight value not recorded

WHO Clinical Stage: __ WHO clinical stage date (dd/mm/yyyy) __ / __ / __ ☐ WHO clinical stage not recorded

E. ART

Was the patient ever started on ART? ☐ Yes ☐ No

Was the treatment preparation completed before the start of ART? ☐ Yes ☐ No ☐ Not on ART

If 'Yes', what is the date of starting ART? (HAART) (dd/mm/yy) __ / __ / ____

F. ART ADHERENCE (For ART patients only)

Was ART Adherence assessment performed during the last 3 months? ☐ Yes ☐ No If yes, last date of assessment __ / __ / ____

Highest CD4 since ART initiation: ____ Date of highest CD4 test (dd/mm/yyyy) __ / __ / ____

G. CLINICAL EVALUATION VISITS IN THE REVIEW PERIOD

Visit 1 (dd/mm/yy):	Visit 2 (dd/mm/yy):	Visit 3 (dd/mm/yy):	Visit 4 (dd/mm/yy):
__ / __ / __	__ / __ / __	__ / __ / __	__ / __ / __

NIGERIAQUAL
ADULT ART AUDIT CHART

H. PATIENT MONITORING DURING REVIEW PERIOD (Values/Test Dates)

CD4 Count	PCV/Hct	Weight (kg)	WHO Stage	Creatinine	ALT
☐☐☐☐	☐☐.☐☐	☐☐☐.☐	☐	☐☐☐☐	☐☐☐☐
__ - __ - __	__ - __ - __	__ - __ - __	__ - __ - __	__ - __ - __	__ - __ - __
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__ - __ - __	__ - __ - __	__ - __ - __	__ - __ - __	__ - __ - __	__ - __ - __

I. ART REGIMEN DURING REVIEW PERIOD (Use codes listed below to indicate date started and changed) (dd/mm/yyyy)

Was the patient on ART on the first day of the review period? ☐ Yes ☐ No

Was the patient on ART any time during the review period? ☐ Yes ☐ No **If Yes, continue**

1st Regimen: ____ Start: ____ / ____ / ________ Change ____ / ____ / ________

2nd Regimen: ____ Start: ____ / ____ / ________ Change ____ / ____ / ________

3rd Regimen: ____ Start: ____ / ____ / ________ Change ____ / ____ / ________

If Other (10 or 22), Indicate Regimen Here ________________________________

Date of last drug pick-up: ____ / ____ / ________

Duration of medication coverage
☐ 1 month ☐ 3 months
☐ 2 months ☐ Other (specify):____________________

ART Medication Regimens

Codes	1st line	Codes	2nd line	Codes	2nd line	Antiretroviral (ARV) Abbreviations	
1	NVP/AZT/3TC	11	LPVr/TDF/FTC or 3TC	23	ATVr/AZT/3TC	AZT	Zidovudine
2	NVP/TDF/FTC or 3TC	12	LPVr/AZT/3TC	24	ATVr/TDF/AZT/FTC or 3TC	3TC	Lamivudine
3	NVP/D4T/3TC	13	LPVr/TDF/AZT/FTC or 3TC	25	ATVr/D4T/3TC	NVP	Nevirapine
4	NVP/ABC/3TC	14	LPVr/D4T/3TC	26	ATVr/ABC/3TC	D4T	Stavudine
5	EFV/AZT/3TC	15	LPV/ABC/3TC	27	2nd line Other	ABC	Abacavir
6	EFV/TDF/FTC or 3TC	16	SQVr/TDF/FTC or 3TC			EFV	Efavirenz
7	EFV/D4T/3TC	17	SQVr/AZT/3TC			TDF	Tenofovir
8	EFV/ABC/3TC	18	SQVr/TDF/AZT/FTC or 3TC			FTC	Emtricitabine
9	ABC/AZT/3TC	19	IDVr/TDF/FTC or 3TC			SQVr	Saquinavir+Ritonavir
10	1st line Other	20	IDVr/AZT/3TC			IDVr	Indinavir+Ritonavir
		21	IDVr/TDF/AZT/FTC or 3TC			LPV/r	Lopinavir+Ritonavir
		22	ATVr/TDF/FTC or 3TC			ATV/r	Atazanavir

J. VIRAL LOAD TESTING (for ART pts only)

Has this patient received VL testing:
☐ Yes ☐ No ☐ Not on ART If yes, Date (dd/mm/yyyy): ____ / ____ / ________ Result (copies/ml): ____________

K. TUBERCULOSIS

Was the patient on TB treatment at the begining of the review perdiod? ☐ Yes ☐ No

Was the patient clinically screened for TB during the review period? ☐ Yes ☐ No ☐ Receiving Treatment

(TB Screening Criteria)
Any cough
Any fever
Any night sweats
Any weight loss

Based on screening, was the patient suspected to have TB? ☐ Yes ☐ No

Did the patient have a CXR performed during the review period? ☐ Yes ☐ No

Was the patient referred to the DOTs Clinic? ☐ Yes ☐ No

NIGERIAQUAL
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Has the patient been evaluated in the review period for TB with sputum smear and/or culture? ☐ Yes ☐ No

Was the patient diagnosed with TB during the review period? ☐ Yes ☐ No If yes, any date of diagnosis: __/__/____

Did the patient start TB treatment? ☐ Yes ☐ No If yes, TB treatment start date: __/__/____

L. COTRIMOXAZOLE

1.Did patient receive cotrimoxazole during the review period? ☐ Yes ☐ No

2. Is the patient currently on Cotrimoxazole prophylaxis? ☐ Yes ☐ No If yes, Date of last prescription: __/__/____
* Check pharmacy form from last visit

M. PHARMACOVIGILANCE (for ART pts only)

Was patient assessed for adverse effects during the review period? ☐ Yes ☐ No ☐ Not on ART

N. Was Hepatitis B assay ever done for this patient? ☐ Yes ☐ No If yes, Result ☐ Positive ☐ Negative

N. Was clinical evaluation form/ART card completely filled at the last visit? ☐ Yes ☐ No

O. CARE AND SUPPORT ASSESSMENT

O1. Is there a Care & Support assessment form in the patient's folder? ☐ Yes ☐ No (If Yes, go to O2, If no, go to P)

O2. Did the patient receive any care and support assessment in the review period? ☐ Yes ☐ No ☐ Not Indicated

O3. Was nutritional assessment ever done for this patient at anytime since enrolment? ☐ Yes ☐ No ☐ Not Indicated

O4. Did the patient receive nutritional assessment within the review period? ☐ Yes ☐ No ☐ Not Indicated

O5. Was the prevention goal documented in the care and support form? ☐ Yes ☐ No ☐ Not Indicated

O6. Has the patient ever received a basic care package? ☐ Yes ☐ No ☐ Not Indicated

O7. Did the patient receive a basic care package anytime within the review period? ☐ Yes ☐ No ☐ Not Indicated

P. PREVENTION

Did the patient receive prevention education during the review period? ☐ Yes ☐ No If yes, Date received: __/__/____
*Guidance: Any education related to sexual or medical transmission in an individual or group session

Q. MISSED APPOINTMENTS AND PATIENT TRACKING *(during review period)*

Misssed appointment (dd/mm/yyyy)	Attempted contact	Date of attempted contact (dd/mm/yyyy)	Outcome of tracking	Reason for LTFU	Cause of death
1. __/__/____	☐ Yes ☐ No	__/__/____			
2. __/__/____	☐ Yes ☐ No	__/__/____			
3. __/__/____	☐ Yes ☐ No	__/__/____			

CODES

Outcome of tracking
1 = LTFU
2 = Transferred
3 = Dead
4 = Returned to care

Reason for LTFU
1 = Spiritual
2 = Self discontinuation
3 = Moved out of area

Cause of death
1 = HIV related
2 = Non-HIV related
3 = Don't know

R. PATIENT STATUS DURING REVIEW PERIOD (with documented evidence)

☐ Transferred out	Date __/__/____	Reason for discontinuing care ☐ Travel ☐ Alternative treatment ☐ Dissatisfaction ☐ Other _____
☐ Dead	Date __/__/____	
☐ Discontinued Care*	Date __/__/____	☐ Not Indicated

** Documented that patient's care giver told providers that will not be receiving care anymore at the facility*