NIGERIAQUAL
PEDIATRIC CHART AUDIT FORM

A. FACILITY DETAILS

FACILITY NAME: ____________________

STATE: ____________________ LGA: ____________________

IMPLEMENTING PARTNER: ____________________

NAME OF ASSESSOR: ____________________

Date of Assessment: __ / __ / ____

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

Ownership: ☐ Public ☐ Private ☐ Faith-based

B. LEVEL (Check one)

☐ Primary Health Centre ☐ Secondary Hospital

Tertiary Hospital

☐ Federal med. Centre ☐ Specialist Hospital

☐ Teaching Hospital

C. PATIENT TYPE (Check One)
Check the status of the patient as at the beginning of the review period

☐ HIV-infected infant age 0 - 24 months

☐ HIV-infected child age > 2 years

D. PATIENT DEMOGRAPHICS

Patient ID ___ - ___ - ___ Hospital No. ____ RNL Serial No. ____

Gender ☐ Male ☐ Female Age: __ ☐ days ☐ weeks ☐ months ☐ years

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

First name: ____________________ Date enrolled in care __ / __ / ____

Did the patient have a clinical visit in the 6 months prior to the review period? ☐ Yes ☐ No *(If No, Please discard form)*

Delivery Location: ☐ This Facility ☐ Other Public Facility ☐ Private Clinic ☐ TBA/Maternity home ☐ Home ☐ Other ☐ Unknown

Primary caregiver: ____________________ Occupation: ____________________

Residential address: State: ____________________ LGA: ____________________

State of origin: ____________________ Tribe: ____________________

Date care ended/Last visit (dd/mm/yyyy): __ / __ / ____ Hospital admission during review period: ☐ Yes ☐ No

E. 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

Was the patient ever started on ART? ☐ Yes ☐ No If 'Yes' what is the date of starting ART (HAART) (dd/mm/yyyy) __ / __ / __

F. 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):

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

CD4 value	CD4 %	Weight (kg)	WHO Stage	PCV/Hct	ALT
____ __ - __ - __	__.__ __ - __ - __	___.__ __ - __ - __	__ __ - __ - __	____ __ - __ - __	____ __ - __ - __
____ __ - __ - __	__.__ __ - __ - __	___.__ __ - __ - __	__ __ - __ - __	____ __ - __ - __	____ __ - __ - __
____ __ - __ - __	__.__ __ - __ - __	___.__ __ - __ - __	__ __ - __ - __	____ __ - __ - __	____ __ - __ - __
____ __ - __ - __	__.__ __ - __ - __	___.__ __ - __ - __	__ __ - __ - __	____ __ - __ - __	____ __ - __ - __

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H. METHOD OF DIAGNOSIS

☐ DNA/PCR	Result	Date Collected (dd/mm/yyyy)	Result Available in Chart	Date reveived (dd/mm/yyyy)
Age of EID #1 ___ ☐ weeks ☐ months	☐ Positive ☐ Negative	__ / __ / ____	☐ Yes ☐ No	__ / __ / ____
Age of EID #2 ___ ☐ weeks ☐ months	☐ Positive ☐ Negative	__ / __ / ____	☐ Yes ☐ No	__ / __ / ____
☐ Rapid Test				
Age ___ ☐ weeks ☐ years ☐ Months ☐ Not indicated	☐ Positive ☐ Negative	__ / __ / ____	☐ Yes ☐ No	__ / __ / ____

☐ Clinical Diagnosis

Age ___ ☐ weeks ☐ years ☐ Months ☐ Not indicated

I. ART REGIMEN SINCE STARTING TREATMENT - During review period (Use codes listed below and indicated dates started and changed

Was the child on ART during the review period? ☐ Yes ☐ No

1st Regimen ___	Start __ / __ / __	Change __ / __ / __
2nd Regimen ___	Start __ / __ / __	Change __ / __ / __
3rd Regimen ___	Start __ / __ / __	Change __ / __ / __

If Other (11 or 25), Indicate Regimen Here ______________________

ART Medication Regimens

Codes	1st line	Codes	2nd line	Antiretroviral (ARV) Abbreviations	
1	NVP/AZT/3TC	20	LPVr/TDF/FTC or 3TC	AZT	Zidovudine
2	NVP/TDF/FTC or 3TC	21	LPVr/AZT/3TC	3TC	Lamivudine
3	NVP/D4T/3TC	22	LPVr/D4T/3TC	NVP	Nevirapine
4	NVP/ABC/3TC	23	LPVr/ABC/3TC	D4T	Stavudine
5	EFV/AZT/3TC	24	LPVr/ABC/ddl	ABC	Abacavir
6	EFV/TDF/FTC or 3TC	25	2nd line Other	EFV	Efavirenz
7	EFV/D4T/3TC			TDF	Tenofovir
8	EFV/ABC/3TC			FTC	Emtricitabine
9	ABC/AZT/3TC			LPV/r	Lopinavir+Ritonavir
10	ABC/3TC/D4T			NLV	Nelfinavir
11	1st line other				

J. ART ADHERENCE (For ART patients only)

Was ART adherence assessment performed during the last 3 months? ☐ Yes ☐ No

If Yes, Date of last assessment in the review period: __ / __ / ____

K. PMTCT AND PERINATAL

I1. Mother's HIV status: ☐ Positive ☐ Negative ☐ Unknown (if negative or unknown, skip this section)

I2. When was the mother diagnosed with HIV? tick appropriately

☐ Before index pregnancy ☐ Antepartum(During pregnancy) ☐ _______ weeks ☐ During labor and delivery ☐ Post-delivery ☐ Not indicated

If diagnosed before index pregnancy, was the mother on ART? ☐ Yes ☐ No

K3. What PMTCT regimen/intervention did the mother receive

Ante-partum	Gestational age at initiation (weeks)	Intra-partum	Post-delivery
☐ ZDV (only opt A)	___	☐ sdNVP+3TC+ZDV (opt A)	☐ ZDV+3TC (option A)
☐ HAART for prophylaxis (opt B)	___	☐ HAART for prophylaxis (opt B)	☐ HAART for breast feeding prophylaxis (opt B)
☐ HAART for treatment	___	☐ HAART for treatment	☐ HAART for lifelong treatment
☐ None	___	☐ None	☐ Not Indicated
☐ Unknown/Not Indicated	___	☐ Unknown/Not Indicated	
☐ Other	___	☐ Other	

K4. Did the infant receive any of the following?

☐ Daily NVP 1 week until breastfeeding ☐ Daily NVP for 6 weeks ☐ sdNVP + daily ZDV for 6 weeks ☐ Other ☐ Not Indicated

K5. Feeding method in the infants first year *(tick all that apply)*

Exclusive Breast Feeding for 6 months	breast milk supplement before 6 months	Mixed with BF before 6 months	Mixed with BF after 6 months	Regular diet for age	Nutritional supplements
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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L. COTRIMOXAZOLE PROPHYLAXIS

Patient currently on Cotrimoxazole: ☐ Yes ☐ No Date Cotrimoxazole first prescribed (dd/mm/yyyy): ___/___/_____ or indicate age at first prescription ___ ☐ Weeks ☐ Months ☐ Years

M. TUBERCULOSIS (Fill this section for only HIV infected infants and children)

1. Was the patient on treatment for TB during review period? ☐ Yes ☐ No ☐ Not indicated If YES go to section N, if NO go to M2.

2. Was the patient screened for TB during the review period? ☐ Yes ☐ No ☐ Not indicated If YES go to M3, if NO go to section N

TB Screening Criteria
- Contact history with a TB case
- Current cough
- Poor weight gain/weight loss

3. Based on screening, was the patient suspected to have TB? ☐ Yes ☐ No ☐ Not indicated

4.1 Was the patient evaluated for TB with sputum/gastric aspirate microscopy or culture? ☐ Yes ☐ No ☐ Not Indicated

4.2 Did the patient have a Chest X-ray? ☐ Yes ☐ No ☐ Not Indicated

4.3 Was the child diagnosed with TB? ☐ Yes ☐ No ☐ Not Indicated If Yes, Date of diagnosis: ___/___/_____

4.4 Was the child started on TB treatment? ☐ Yes ☐ No ☐ Not Indicated If Yes, indicated date of starting TB treatment: ___/___/_____

N. EDUCATION

Did mother receive infant feeding education at any time? ☐ Yes ☐ No ☐ Not Indicated

O. LINKAGES

1. Did patient receive nutrition assessment (documented in chart) during review period? ☐ Yes ☐ No If YES go to 2, if NO go to 3.

2. Did the patient qualify for nutritional support? ☐ Yes ☐ No ☐ Not Indicated

2.1. If 'Yes' did the patient receive nutritional support? ☐ Yes ☐ No ☐ Not Indicated

3. Did the patient receive the following services (during review period)? ☐ Water guard ☐ Insecticide treated nets ☐ Not Indicated ☐ None

4. Child's immunization status: ☐ Up to date ☐ Incomplete ☐ Vaccination needed ☐ Not indicated

P. DOCUMENTATION

1. Is the growth chart in the case note? ☐ Yes ☐ No If YES go to 2, If NO go to 3

2. Does the patient have the following measurements in the chart/ growth?
Baseline: ☐ Weight ☐ Height/Length ☐ MUAC
Last Visit: ☐ Weight ☐ Height/Length ☐ MUAC
Indicate value of weight and height/length measurement at last visit: ___.___ kg and ___.___ cm

3. Were the developmental milestones documented in the last visit? ☐ Yes ☐ No (For children under 5 years)

4. Is there a Care and Support assessment form in the patient's folder? ☐ Yes ☐ No

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 (With documented evidence)

☐ Transferred out Date: ___/___/_____
☐ Dead Date: ___/___/_____
☐ Discontinued Care* Date: ___/___/_____

Reason ☐ Travel ☐ Alternative treatment ☐ Dissatisfaction ☐ Other ☐ Not Indicated _____

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