Psychosocial Screening Form

(NB: *Please tick where applicable*)

i)Patient ☐ Transfer in (Date:_____) ☐ Transfer out (Date:_____) (Site: _____)
Place Patient referred from: _____ (Date :_____) To (Site):_____

ii) Date of Allocation to PA (dd/mm/yyyy: _____

iii) Child headed household: ☐ Yes ☐ No

iv) Patient accepted PA & Home visits ☐ only facility based support ☐
(If yes, contract form attached)

v) Assessment Completed at: ☐ Facility ☐ Home

vi) CD4 Count: _____ vii) Viral Load (VL) _____

viii) ART start Date (dd/mm/yyyy): _____

ix) Diagnosed TB on:

(a) Sputum	Yes/ No	Date diagnosed: _____
(b) X-ray	Yes/ No	Date diagnosed: _____
(c) Clinical observation	Yes/ No	Date diagnosed: _____
(d) TST	Yes/ No	Date diagnosed: _____

x) Date Enrolled in HIV care eligible for HAART: _____

xi) Screening Done At: ☐ Baseline ☐ 6 months ☐ 12 months ☐ 24 months
☐ 36 months ☐ 48 months ☐ 60 months

xii) PA Name _____ **PA Surname** _____

If patient is a child, interview the Primary Care Giver of the child:

Primary Care Giver's Name: _____ Surname: _____

Relationship to the child? _____

Patient Details

1. Patient's Full Name: _____ _____ **Surname**:_____

a. **Gender :** ☐ Female ☐ Male

b. **Age:** _____ **Date of Birth (DD/MM/YYYY):** _____ **I.D. No.** _____ _____

2. Patient's Folder Number (As in clinic folder): _____PMTCT folder No._____

3. Residential Address of patient (Tick if changed in the last six months ☐): _____

_____

Contact Telephone Numbers (number where patient can be reached):

Home: _____ Work: _____ Cell phone: _____

Is your home... ☐ Your own ☐ shared, with whom_____ ☐ Formal ☐ Shack

4. Do you have access to a fridge? (Specifically for storing medication) ☐ Yes ☐ No

Details of Next of Kin

6. Next of Kin Name : _____ Surname:_____

7. Residential Address: _____

Contact number: Cell _____ Home: _____

Treatment buddy and Disclosure Section (If patient is a child, question primary caregiver)

☐ No,
why?.....
.....

8. Is there somebody that could be your treatment buddy? ☐ Yes
(Preferably family member or close relationship to support who live in the vicinity)

9. Treatment Buddy Details:

a: Name _____ Surname: _____

b: Date of Birth: _____Relation with person: _____

b: Residential Address: _____

_____

C: Contact Numbers: Home _____Work: _____

Cell phone: _____

10. Does your partner know his/her status? ☐ Yes ☐ No ☐ N/A

If not (write action to be taken): _____

11. To whom have you disclosed your status?

Partner: ☐ Yes, when? _____ ☐ No ☐ N/A Family: ☐ Yes, when? _____ ☐ No ☐ N/A

Children: ☐ Yes, when? _____ ☐ No ☐ N/A Friends: ☐ Yes, when? _____ ☐ No ☐ N/A

Others (specify): _____ When? _____

12. Do you need help with disclosure? ☐ Yes ☐ No

If you need help disclosure can I refer you someone who can help you? ☐ Yes ☐ No

13. Have [child's name] parents been tested? Yes ☐ No ☐ Don't know ☐ N/A

TB Section

Questions directed at Patient (if patient is TB positive at present do not ask, skip to Question16

14. Have you been coughing for more than 2 weeks, lost weight, produced sputum (may be blood stained) , experienced loss of appetite, felt tired and weak, shortness of breath and chest pains, night sweats or fever?

☐ **Yes** ☐ **No**

Have you ever been screened for TB?

☐ Yes, reason (s) _____ _____

When: _____ (if more than 6 months ago refer for screening)

ACTION: _____

☐ No, reason (s) _____

Questions for Household members

15. Has anyone in the household been screened for TB?

☐ Yes, reason (s) _____

_____

When: _____ (if more than 6 months ago refer for screening)

ACTION: _____

☐ No, reason (s) _____

ACTION: _____

16. Does anybody else in the household have TB? ☐ Yes ☐ No

a) If yes, who:

_____

b) Are they using TB: (a) treatment? ☐ Yes, Start date: _____ ☐ No ☐ Don't Know

Has anybody in this household been coughing for more than 2 weeks, lost weight, produced sputum (may be blood stained) , experienced loss of appetite, felt tired and weak, shortness of breath and chest pains, night sweats or fever?

☐ Yes ☐ No

Names and surnames of Household members referred for TB Screening:

1) _____ (3)_____

2) _____ (4)_____

If patient is a child: use your judgement in asking the following questions. If these questions MAY be relevant in the life of the child – ask them.

Some of the questions I'm going to ask you now are sensitive. I need to ask them so that we can support you as best as we can. All information is confidential – it will be used by your team of carers.

17. Are you taking any tradition or other medication at the moment?

☐ Yes ☐ No

18. Do you smoke cigarettes?

☐ Yes ☐ No **If yes, how many a day?** _____

19. How often do you drink alcohol?

☐ None ☐ Every day ☐ Few times a week ☐ Few times a month

20. How often do you use drugs?

☐ None ☐ Every day ☐ Few times a week ☐ Few times a month

21. Do you think you need help with alcohol and / or drug abuse?

☐ Yes ☐ No ☐ Don't Know ☐ N/A

22. Are you or your partner using any form of contraception?

☐ Yes ☐ No ☐ N/A

If yes, what kind _____

23. Do you plan to have more children? Do you plan to fall pregnant again?

☐ Yes ☐ No ☐ Don't Know ☐ N/ A

24. If you have children, which clinic do you take your children to?_____ N/A ☐

25. Did you use any form of protection (e. g condoms) the last time you had sex?

☐ Yes ☐ No ☐ Can't remember ☐ N/A

26. How often do you use protection (e. g condoms)?

☐ Always ☐ Sometimes ☐ Never ☐ N/A

27. Is there any of abuse such as domestic Violence affecting the family – such as wife beating or vice versa or child abuse? (Do not ask the patient this question ONLY make observation)

☐ Yes ☐ No ☐

Household Section

(28) List ALL members of this household (Table 1)

Name	Surname	Relation to patient	Gender (Male/Female	Date of birth (dd/mm/yyyy)	HIV tested (yes/no)	HIV Test result Positive/Negative	TB screened (Yes/No)	TB result Positive/Negative)
Patient								

29. **Who is the primary provider in this household?**

(a) ☐ Patient

(b) ☐ Someone else, provide details below:
Name: _____ Surname: _____
ID: _____

30. **What is the total monthly income in the household if you add it all together (excluding grants)?**

☐ No income ☐ R800 or less ☐ Between R800 and R1,200 ☐ Between R1,200 and R2,000 ☐ Between R2,000 and R2,400

31) List household members in need and referred for the following interventions. (Names MUST be among those listed in Table 1)

Name	Surname	Birth Certificate (Yes/No)	13 digit bar coded Identity document (Yes/No)	Signs of Abuse (look for signs of abuse) (Yes/No)	Signs of Neglect (look of signs) (Yes/No)	Death certificate (Yes/No)	Marriage certificate (Yes/No)

32) List household members in need of household strengthening intervention (Names MUST only be among those listed in Table 1)

Name	Surname	Child support grant (Yes/No)	Care dependency Grant (Yes/No)	Disability Grant (Yes/No)	Social relief war veteran grant (Yes/No)	Old Age Pension (Yes/No)	Foster care grant (Yes/No)

33) List household members in need and referred for the following interventions (Names MUST only be among those listed in Table 1)

Name	Surname	General health care		Psychological care		Other referral			
		Health care service (Y/N)	IMCI (Y/N)	Clinical Psychological Therapy (Y/N)	Counselling (Y/N)	PMTCT (Y/N)	PCR (Y/N)	HCT (Y/N)	TB screening (Y/N)

34. Do you receive support for at any of the following? (To be completed after six months not at Baseline)

ART ☐ Yes ☐ No ☐ N/A	**TB** ☐ Yes ☐ No ☐ N/A
Support groups: Yes, how? _____ _____ No, why not? _____ _____	Support groups: Yes, how? _____ _____ No, why not? _____ _____
Clinic: Yes, how? _____ _____ No, why not? _____ _____	Clinic: Yes, how? _____ _____ No, why not? _____ _____
Family: Yes, how?_____ _____ No, why not? _____ _____	Family: Yes, how? _____ _____ No, why not? _____ _____
Patient Advocate: Yes, how so? _____ _____ No, why not? _____ _____	Patient Advocate: Yes, how so? _____ _____ No, why not? _____ _____

35. Declaration

I,..... (Print PA name and surname) acknowledge that the information contained herein this psychosocial form is correct and truly reflects *ONLY* the views of the patient.

Signature of the PA:..... **Date:.....**

Signature of the patient:..... **Date:.....**
(primary caregiver will sign if patient is a child)

36. Psycho-Social Screening Summary[1]

Patient Name: Surname:	ID Number: DOB (DD/MM/YYYY):	Folder Number:
Gender:	Patient Advocate	Site: Date form completed:

Challenges Identified (please tick the appropriate box/es):

1. Not disclosed		2. No treatment buddy		3. Substance Abuse	
4. Domestic Violence		5. Depression		6. Severely ill/ opportunistic infections	
7. On TB Treatment		8. Chronic illness _____		9. Child	
10. Adolescent		11. Pregnant		12. Post-Delivery (less than 6 weeks)	
13. IMCI		14. Clinical Psychological Therapy/counselling		15. Household Economic Strengthening	
16. No income		17. Other: _____			

Adherence Plan (please tick the appropriate box/es): Date (DD/MM/YYYY): _____

	Tick	Reason		Tick	Reason
1. VIP			2. NOT VIP		
3. Facility Based Support			4. Home Based Support		

[1] Copy to be kept in clinical Folder

37. Intervention Plan

Intervention	Progress /process	Date	Outcome	Date
Clinic treatment				
Support group				
Disclosure				
Clinic adherence Counselling				
Household Economic Strengthening				
Hospice/ Home Based Care (HBC)				
Protection (ID, BC, Abuse, neglect , MC, DC)				
Other Referral: PMTCT, HCT, TB Screening, PCR				

Checked By: _____ Date: _____

Designation: _____

INTRODUCTION

HOME ASSESSMENT

If this is your first contract with your client – please explain who you are and what role you will be playing in their treatment.

Read this page before you meet the client, so that you can explain to them without having to read from this page – just explain to them in a normal way as if you are talking to them.

My name is _____ and I am a community adherence worker appointed by the clinic to support you with your treatment. Have they told you about me? Have you been expecting a visit from me? Is it OK to talk to you now or shall I come back later?

[Make an appointment if the client cannot see you now. If it is convenient, continue with the Home Assessment]

One o f the first things that I need to do to support you are to find out more about your environment – your home, your support and so on. The information will be used by me, by the doctors and by the nurses at the clinic to care for you in the best way possible. With this information, we can help you to get ready for treatment as soon as possible. It will take me about an hour today to start this process. Is it okay to continue now; do you have time now?

Some of the questions may be a bit uncomfortable to answer; please answer as openly as you can. You can be assured that the information is confidential. It will only be used by the people who care for you at the clinic. We need to have this information to be able to give you the best support and advice to make your treatment successful so that you can get well as soon as possible.