



FORM 3: ADULT PATIENT COUNSELLING FORM

(Form filled in by Counsellor)

South African ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--

Capturer:

--	--	--

Date of Visit:

d	d	m	m	y	y	y	y
---	---	---	---	---	---	---	---

A. GROUP COUNSELLING SESSIONS

Positive Living/Patient Literacy 1

Due Date <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Attend <input type="radio"/> Yes <input type="radio"/> No	Date Attended <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Counsellor <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						
d	d	m	m	y	y	y	y																		
d	d	m	m	y	y	y	y																		

Drug Readiness/Patient Literacy 2

Due Date <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Attend <input type="radio"/> Yes <input type="radio"/> No	Date Attended <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Counsellor <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						
d	d	m	m	y	y	y	y																		
d	d	m	m	y	y	y	y																		

Drug Adherence

Due Date <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Attend <input type="radio"/> Yes <input type="radio"/> No	Date Attended <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Counsellor <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						
d	d	m	m	y	y	y	y																		
d	d	m	m	y	y	y	y																		

Nutritional Assessment

Due Date <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Attend <input type="radio"/> Yes <input type="radio"/> No	Date Attended <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Counsellor <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						
d	d	m	m	y	y	y	y																		
d	d	m	m	y	y	y	y																		

Other Patient Training (Specify) →

--

Due Date <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Attend <input type="radio"/> Yes <input type="radio"/> No	Date Attended <table border="1"> <tr> <td>d</td><td>d</td> / <td>m</td><td>m</td> / <td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	d	d	m	m	y	y	y	y	Counsellor <table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>						
d	d	m	m	y	y	y	y																		
d	d	m	m	y	y	y	y																		

B. DISCLOSURE

1. Has the patient disclosed to anyone? Yes No

If Yes, to whom:

- Partner
- Family Member
- Household Member
- Friend
- Health Care Provider
- Employer
- Other (Specify) →

--

C. TREATMENT SUPPORTER

Name:

--

Address:

--

Tel (work):

--	--	--	--	--	--	--	--	--	--

Tel (cell):

--	--	--	--	--	--	--	--	--	--

Comments:
