CAG Group monitoring Form

Facility Name: **CAG Group Number:**

Focal Person Name: **Focal Person Contact Number:** **Name of Meeting Place:**

Date Completed by CAG Focal Person __ __/ __ __ /__ __ __ __ **Signature of Focal Person:**

To be Completed By CAG Focal Person									To be Completed By Nurse				To be Completed By CAG Member		
CAG Member Number	First Name	Surname	ARV regimen	On CTX Y/N	Pregnant (P) or on family planning (FP)	TB symptoms* Y/N	Other "Alert" problems**	ARV Tablets remaining	ARV regimen prescribed	CTX Y/N	VL result	Date VL	Signature of Recipient	Date Drugs Received	Comments (include any reason for temporary clinic follow up***)
1												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
2												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
3												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
4												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
5												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
6												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
7												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
8												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
9												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
10												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
11												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
12												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
13												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
14												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	
15												__ __/__ __/__ __ __ __		__ __/__ __/__ __ __ __	

*TB Symptoms: Ask if the member has had a cough for more than 2 weeks. Ask if member is losing weight

**Alert problems: Ask if the member has any ankle swelling, puffiness of the face, breathlessness, diarrhea for more than 2 weeks, severe headache

***Reasons for temporary clinic follow up: 1. Pregnant 2. Mum with exposed baby 3. VL > 1000 and needs Enhanced Adherence 4. New TB diagnosed 5. New OI 6. Significant adherence problem 7. Other

Date Nurse Prescribed for CAG : __ __/__ __/ __ __ __ __ **Nurse Signature:**