health
Department:
Health
REPUBLIC OF SOUTH AFRICA

MMC CLIENT INTAKE FORM

Client File Number: _____

F1. INFORMED CONSENT FOR HIV TESTING SERVICES (HTS) — Page 4

Client First Name(s)		Surname	

- I, the above-mentioned, hereby declare that I was informed and freely offered HIV Testing Services. I understand that HIV test results are kept confidential and that only healthcare providers and the individual tested have access to the test results. I give consent that my information will be shared with authorised healthcare providers in the best interest of my health and with the Department of Health for monitoring and evaluation purposes.
- Be contacted telephonically on my mobile number supplied for follow-up.

Please check the relevant box below:

☐ I consent to be tested for HIV, to have my HIV status shared with me and my healthcare providers; and to be contacted for follow up
☐ I choose to decline HIV testing

Signature of Client		Date of consent	DD/MM/YYYY

F2. PARENT/LEGAL GUARDIAN CONSENT FOR HIV TESTING (CLIENT YOUNGER THAN 12 YEARS)

Name & Surname of Parent/Guardian		Signature of Parent/Guardian	
Date of consent	DD/MM/YYYY	Identity Number of Parent/Guardian	

G1. INFORMED CONSENT FOR MEDICAL MALE CIRCUMCISION (MMC) – *OR ASSENT FOR CLIENT 10-17 YEARS*

First Name(s)		Surname	

- I, the above-mentioned, hereby declare that I was informed and voluntarily accepts to undergo medical male circumcision. I understand that VMMC is a surgical procedure that offers partial protection against HIV infection. With any medical or surgical procedure there are risks involved. The circumcision procedure and its possible outcomes including complications have been fully explained and discussed with me.
- I was informed that I might be contacted telephonically on my mobile number supplied for follow-up. Please check the relevant box below:

☐ I consent for medical male circumcision
☐ I choose to decline medical male circumcision

Signature of Client		Date of consent	DD/MM/YYYY

G2. PARENT/LEGAL GUARDIAN CONSENT FOR MEDICAL MALE CIRCUMCISION (CLIENT 10-17 YEARS)

Name & Surname of Parent/Guardian		Signature of Parent/Guardian	
Date of consent	DD/MM/YYYY	Relationship to Client	

G3. COUNSELLOR (& surgeon/clinical associate & nurse) PROVIDING CLIENT WITH HTS AND VMMC INFORMATION

First Name(s) of Counsellor		Surname of Counsellor	

I am the counsellor who has provided the above-mentioned client and/or his parent/legal guardian with information related to HTS and VMMC. I have given the client and/or his parent/legal guardian an opportunity to ask me questions and have ensured that they understand the information provided. To the best of my assessment, the client and/or his parent/legal guardian are capable of giving consent and have sufficient information to make a decision about whether to proceed with HIV counselling and testing, and voluntary medical male circumcision procedure.

Signature of Counsellor		Date	DD/MM/YYYY
Signature of Surgeon/Nurse		Date	DD/MM/YYYY

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A. FACILITY AND CLIENT INFORMATION — Page 1

A1. VMMC SETTING – *To be completed by data clerk*

Province		District	
		Sub-district	
Facility Name		Facility Type	☐ Static ☐ Mobile ☐ Outreach ☐ Other, specify: _____
Date of Visit	DD/MM/YYYY	Name of Data Clerk	Data Clerk signature

A2. CLIENT INFORMATION – *To be completed by data clerk*

First Name(s)		Surname		Age (Years)	
ID Number				Date of Birth	DD/MM/YYYY
Mobile Telephone Number		Physical Address		Employment Status	☐ Fulltime ☐ Part-time ☐ Contract ☐ Student ☐ Unemployed
Relationship Status	☐ Married, 1 Spouse ☐ Married, Polygamous ☐ Single, No Regular Partner ☐ Single, Regular Partner ☐ Divorced/Separated ☐ Widowed, Other, specify: _____				
Can next of kin be contacted?	☐ Yes ☐ No	Names of next of kin		Telephone of next of kin	

A3. HIV TESTING INFORMATION – *To be completed by nurse/counsellor*

Have you ever tested for HIV?	☐ Yes ☐ No	If yes, when was the most recent HIV test?	☐ ≤1 month ☐ ≤3 months ☐ ≤6 months ☐ ≤1 year ☐ >1 year		
		If yes, what was the most recent test result?	☐ Negative (NR) ☐ Positive (R) ☐ Never collected result		
		If HIV positive, have you attended an HIV care facility for care and treatment in the past 3 months?	☐ Yes, name of facility:_____ ☐ No, referred to facility:_____ Name of staff referring to ART:_____	On ART?	☐ Yes ☐ No

A4. HIV TESTING SERVICES (HTS) – *To be completed by nurse/counsellor*

Declined testing?	☐ Yes ☐ No	Consented?	☐ Yes ☐ No	Result 1 Result 2	☐ Negative (NR) ☐ Positive (R) ☐ Discordant ☐ Negative (NR) ☐ Positive (R) ☐ Discordant ☐ ELISA test	Results given?	☐ Yes ☐ No
Final Result	☐ Negative (Neg) ☐ Positive (Pos)	Risk Reduction	☐ Condom usage ☐ Partner reduction ☐ Follow-up counselling (negative and high-risk factors)				

A5. SEXUALLY TRANSMITTED INFECTION (STI) SCREENING – *To be completed by nurse/counsellor*

Have you ever been tested/treated for STIs?	☐ Yes ☐ No	Have you had genital sores or ulcers?	☐ Yes ☐ No	Do you have burning when passing urine?	☐ Yes ☐ No
Do you always use condoms when having sex?	☐ Yes ☐ No	Have you had discharge from your penis?	☐ Yes ☐ No	How many sexual partners have you had in the last 6 months?	

A6. TUBERCULOSIS (TB) SCREENING – *To be completed by nurse/counsellor*

Have you had a cough for ≥2 weeks OR any duration if HIV positive?	☐ Yes ☐ No	Have you had a persistent fever for more than 2 weeks?	☐ Yes ☐ No	Have you had unexplained weight loss >1,5kg per month?	☐ Yes ☐ No
Do you have night sweats?	☐ Yes ☐ No	Have you ever had contact with a person with TB?	☐ Yes ☐ No	Have you ever been previously diagnosed with TB?	☐ Yes ☐ No
A Yes to any of these questions may indicate possible active TB. If client screens positive for possible TB infection, refer them to TB clinic for further evaluation. Patient may continue to receive MMC.				If you have been diagnosed with TB, have you completed your TB treatment?	☐ Yes ☐ No

A7. REFERRALS – *To be completed by nurse/counsellor*

Referred for:	☐ ART/wellness ☐ STI treatment ☐ TB evaluation ☐ General health facility Other, specify: _____

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B. SOCIO-MEDICAL HISTORY — Page 2

B1. REFERRAL MECHANISMS – *To be completed by nurse/counsellor*

How did you learn of VMMC?	☐ Friends/Family ☐ Partner/Spouse ☐ Other Client ☐ Health Worker ☐ Community Mobilizer ☐ Community Event ☐ Church Event ☐ Branded Taxis ☐ Billboard ☐ TV/Radio ☐ Social Media (e.g. Facebook) ☐ Poster/Newspaper/Leaflet ☐ Phone/SMS ☐ Other, specify: _____

B2. REASONS FOR CIRCUMCISION – *To be completed by nurse/counsellor*

What are your primary reasons for VMMC?	☐ Partial HIV Protection ☐ STI Protection ☐ Hygiene ☐ Medical ☐ Social/Religious ☐ Appearance ☐ Sexual Pleasure ☐ I was ready today ☐ I just decided to come ☐ Other, specify:_____

B3. PAST MEDICAL HISTORY – *To be completed by nurse*

Do you have any of the following conditions?	Anaemia	☐ Yes	☐ No	If yes, are you currently receiving treatment?	☐ Yes	☐ No
	Haemophilia/bleeding disorders in yourself or family	☐ Yes	☐ No	If yes, are you currently receiving treatment?	☐ Yes	☐ No
	Nose bleeds that last long time?	☐ Yes	☐ No	If yes, are you currently receiving treatment?	☐ Yes	☐ No
	Diabetes	☐ Yes	☐ No	If yes, are you currently receiving treatment?	☐ Yes	☐ No

B4. COMPLAINTS – *To be completed by nurse*

Do you have any of the following complaints?	Urethral discharge	☐ Yes	☐ No	Difficulty retracting foreskin	☐ Yes	☐ No
	Genital sore/ulcer/warts	☐ Yes	☐ No	Swelling/redness of foreskin/penis	☐ Yes	☐ No
	Swelling of the scrotum	☐ Yes	☐ No	Discharge or thick liquid under foreskin	☐ Yes	☐ No
	Frequent urination	☐ Yes	☐ No	Pain on erection	☐ Yes	☐ No
	Difficulty passing urine	☐ Yes	☐ No	Concerns about erection/sexual function	☐ Yes	☐ No
	Pain on urination	☐ Yes	☐ No	Other, specify		

B5. PREVIOUS SURGERY – *To be completed by nurse*

Have you ever had a dental or surgical operation?	☐ Yes	☐ No	Nurse	Name:
If yes, specify nature, date, and any complications				Signature:

B6. CURRENT MEDICATIONS AND ALLERGIES – *To be completed by nurse*

Taking Any Medications?	☐ Yes	☐ No	Allergies to Medications?	☐ Yes	☐ No
Specify			Provide details (e.g. Iodine => rash)		

C. PHYSICAL EXAMINATION AND TRIAGE

C1. PHYSICAL EXAMINATION – *To be completed by nurse*

Phimosis	☐ Yes ☐ No	Paraphimosis	☐ Yes ☐ No	Epispadias	☐ Yes ☐ No	Hypospadias	☐ Yes ☐ No	Genital Ulcers/Warts	☐ Yes ☐ No
Balanitis	☐ Yes ☐ No	Torsion	☐ Yes ☐ No	Adhesions	☐ Yes ☐ No	Urethral discharge	☐ Yes ☐ No	Other, specify	

C2. WELLNESS ASSESSMENT – *To be completed by nurse*

Weight	kg	Blood pressure		Pulse		Temperature	◦C	Urinalysis	
Pallor	☐ Yes ☐ No	Lymph-adenopathy	☐ Yes ☐ No	Wasting	☐ Yes ☐ No	Hemo Glucose test (HGT)		Respiration Rate	
								Haemoglobin (HB)	

C4. VMMC ELIGIBILITY – *To be completed by nurse*

Is client eligible for VMMC?	☐ Yes	☐ No	If no, specify	

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D. VMMC PROCEDURE — Page 3

D1. VMMC OPERATION – *To be completed by surgeon/clinical associate & nurse*

Date of VMMC	DD/MM/YYYY	Start Time	HH:MM	End Time	HH:MM		Consent for MMC Verified?	☐ Yes	☐ No
Anaesthetic (give according to weight of client)	☐ Macaine 0.5%	ml	Skin Prep	☐ Povidone Iodine		MMC Provider	Name:		
	☐ Lignocaine 1%	ml		☐ Other, specify:			Designation:		
	☐ Lignocaine 2%	ml	Anesthesia	☐ DPNB			Signature:		
	☐ EMLA cream	ml		☐ DPNB + Ring Block		1st Assistant	Name:		
Method	☐ Dorsal Slit (all clients <15 years)		Suture	☐ Plain Gut			Designation:		
	☐ Forceps Guided			☐ Vicryl Rapide			Signature:		
	☐ Sleeve Resection			☐ Chromic		2nd Assistant	Name:		
	☐ Device/Surgical aid, specify (type/size): _____/_____						Designation:		
Diathermy Used?	☐ Yes	☐ No	Diathermy Setting	☐ 18-25 ☐ 26-30			Signature:		

D2. POST-SURGERY OBSERVATION (IMMEDIATELY AFTER PROCEDURE) – *To be completed by surgeon/clinical associate & nurse*

BP	/	Temp.	◦C	Pulse		Respiration rate	

D3. POST-SURGERY OBSERVATION (15 MINUTES AFTER PROCEDURE) – *To be completed by surgeon/clinical associate & nurse*

BP	/	Temp.	◦C	Pulse		Respiration rate	

Complications/Intra-Operative AEs? ☐ Yes ☐ No If "Yes" Mark all AE codes that apply below:

☐ Anaesthetic Reaction (AR)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Insufficient Skin Removal (IS)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)
☐ Bleeding (BL)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Occupational Exposure (OT)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)
☐ Damage to Penis (DP)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Pain (PA)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)
☐ Excess Skin Removal (ES)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Other, Specify:	

CLINICAL NOTES

E. POST-OPERATIVE REVIEW VISITS – *To be completed by surgeon/clinical associate & nurse*

E1. 48 Hours Post-Operative/First Visit

Date of Visit	DD/MM/YYYY	Reviewed By	
AE Present?	☐ Yes ☐ No	Notes	
AE Code	Severity Code	Diagnosis Date at this Severity	
		DD/MM/YYYY	
		DD/MM/YYYY	
Signature			

E2. 7 Days Post-Operative/Second Visit

Date of Visit	DD/MM/YYYY	Reviewed By	
AE Present?	☐ Yes ☐ No	Notes	
AE Code	Severity Code	Diagnosis Date at this Severity	
		DD/MM/YYYY	
		DD/MM/YYYY	
Signature			

Post-Operative AEs? Yes ☐ No ☐ If "Yes – Mark all AE codes that apply below:

☐ Bleeding (BL)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Insufficient Skin Removal (IS)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)
☐ Damage to Penis (DP)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Pain (PA)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)
☐ Excess Skin Removal (ES)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Wound Disruption (WD)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)
☐ Infection (IN)	☐ Mild (1) ☐ Moderate (2) ☐ Severe (3)	☐ Other, Specify:	

E3. LOST TO FOLLOW UP - *To be completed by surgeon/clinical associate & nurse*

Lost-to-Follow-Up?	☐ Yes ☐ No	Attempted to Call?	☐ Yes ☐ No	Follow-Up at Another Site	☐ Yes ☐ No	Specify	