PrEP Initial Visit

Name: **DOB:**
Gender at birth: **Gender identity:**
Preferred pronouns: **Preferred mode of contact:**
Interpreter assistance needed:

Previously on PrEP: Yes No	If yes, info here:
On PrEP now: Yes No	**Daily or EBD?**
Last negative HIV test: where and when	

Sexual Health History and PrEP Assessment

What is patient's reported need for PrEP? (i.e. "Why would you like to take PrEP?")	gbMSM condomless anal sex HIV serodifferent sexual relationship Heterosexual condomless vaginal/anal sex Other, give details	
Number of condomless sexual partners in the past 6/12	Types of sex, tick all that apply: Oral Receptive anal Insertive anal Insertive vaginal/frontal Receptive vaginal/frontal	
Most recent condomless sex: **Needs PEP? Yes No** **Recent unprotected exposure and symptoms of HIV seroconversion?** **Yes No**	Type of sex, tick all that apply: Oral Receptive Anal Insertive Anal Insertive Vaginal/frontal Receptive Vaginal/frontal	
Condom use	Always Sometimes Never	Likely to have condomless anal/vaginal sex in the next 3 months? Yes No
Any partner living with HIV?	If yes, is person on ART with undetectable HIV Viral load?	
Acute STI in the past 6/12?	Yes No	Details here
PEP in the past 6/12?	Yes No	Details here
Use of chemsex in the past 6/12?	Yes No	Chems details Any injecting?
LMP:	Contraception: Yes No	

Cervical screening history	
In general how many times is PrEP protection needed per week, not 2 consecutive days? *If >2 times (not consecutive days) daily dosing schedule more suitable*	
In general can patient plan for event based schedule to allow for 2 hours to protection from double dose TDF/FTC? *If no, event based dosing may not be suitable*	
Important to highlight to patients who have a steady partner and an open relationship that they may benefit from PrEP protection with their steady partner.	

Medical History

Past Medical History: (*Including Renal, bone, DM, HTN):*	
Previous syphilis: Document where, stage and treatment *NB – if any uncertainty about syphilis treatment or serology interpretation, refer to specialist STI clinic*	
Family History:	

Regular Medications and OTC (*Nephrotoxic medications, NSAIDs, etc*) Please List:	
	Protein supplements Yes No
Allergies Yes No	**Document allergies here:**

Social History

Tobacco smoker Yes No	
Alcohol Yes No	Units p/w_____
Recreational drugs Yes No	H/o injecting: Yes No
List recreational drug list here:	
Country of Birth:	Occupation:

STI symptoms checklist

If symptoms of an STI carry out appropriate examination and investigations	
Urethral discharge	Change/abnormal PV discharge
Dysuria	Intermenstrual bleeding
Abdominal pain	Post coital bleeding
Rectal pain	Dyspareunia
Rectal discharge and or bleeding	Other

Vaccinations

Hepatitis A	Immune	Non-Immune	Unknown	
Hepatitis B	Immune	Non-Immune	Unknown	
HPV	Immune	Non-Immune	Unknown	

Mpox	Immune Non Immune Unknown	
Other		

Patient Counselling

Daily PrEP and Event Based PrEP explained	Yes No
Side-effects of PrEP discussed	Yes No
Adherence to dosing schedule discussed	Yes No
Missed doses discussed and what to do, when PEP needed	Yes No
Safe PrEP start	Yes No
Safe PrEP stop	Yes No
Regular HIV testing, STI screening, and monitoring of renal function discussed	Yes No
Potential Risk of decrease in bone mineral density discussed, **esp if patient is aged <24** and/or risks for low bone mineral density	Yes No
Condoms/lube (to prevent other STIs) offered	Yes No
PEP and how, when to access discussed	Yes No
Questions/queries answered	Yes No
Signposted to information resources	Yes No

Plan

Suitable for PrEP	What kind of PrEP protection needed? *Circle all relevant* Anal receptive Anal insertive Vaginal/frontal insertive Vaginal/frontal receptive	
Dosing schedule decided	Daily Dosing Event Based Dosing	
Needs repeat HIV test in 4 - 6 weeks? I.e. is currently within the HIV window period?		
PrEP prescription given and duration of script?	Yes No	1/12 3/12 6/12
Confirmed how to contact with today's HIV test result? Yes No	Patient aware to wait for result of today's HIV test before starting PrEP Yes No	
Chlamydia and Gonorrhoea testing Yes No	Urine Vaginal Anal Throat If no, date of most recent negative STI testing:	
Blood testing	HIV HAV HBV HCV Syphilis Renal	
Treated for STI Yes No	GC CT Syphilis Others:	
Vaccinations	HPV HAV HBV Other:	
DPS	Registered Need registration	

NOTES:

Signed: …… Grade: ……..…….…… MCRN/NMBI: ……..…