PrEP Review Visit

MRN_____ **DPS** _____ **Clinic Date:** _____/_____/_____

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: **Any missed PrEP doses? Yes No** **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.

Review/Medical Notes

Patient happy to continue PrEP	Yes No
(if not, give reasons and discuss when to access PEP and PrEP and how)	
Any side effects? Yes No	Nausea Bloating Diarrhoea Others:
Issues with adherence? Yes No	
Any medical issues since last visit? Yes No	
Any new medications since last visit? Yes No	
Any changes in social history? (smoking, drugs, alcohol) Yes No	
Any symptoms of an STI – check for systems and proceed with examination as required	

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 (lead in time)	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	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 and Tests

Continue PrEP	*If stopping PrEP, document reason and check patient knows when to access PEP*	
Dosing schedule decided	Daily Dosing Event Based Dosing	
PrEP prescription given and duration of script?	Yes No	1/12 3/12 6/12
(if not, give reasons)		
STI testing Yes No	Urine Throat Anal Vaginal If no, date of most recent negative STI testing:	
Blood testing	HIV Renal HCV Syphilis	
Treated for STI Yes No	GC CT Syphilis Other_____	
Vaccination Update		
Confirm contact details		

NOTES:

Signed: …… Grade: ……..…….…… MCN: ……