First Visit Basics:

Initiating Care for the HIV-infected Patient

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Welcome to this short guide to initiating care for a new patient with HIV infection. We have found that the first visit can be critical in establishing an on-going relationship for patients with this chronic disease, but we are also aware that time is limited. The following overview provides a succinct description of the initial history and physical, lays the groundwork for continuing care, and lists easily accessible resources.

In addition, we have taken the liberty of providing two examples of flow sheets that can provide continuing documentation for these patients. Please feel free to copy the forms for your personal or clinic use.

CHIEF COMPLAINT. Patients may present with a complaint such as thrush, but initial visits often occur as a result of having a positive HIV antibody test.

ASSESS HISTORY

HISTORY OF PRESENT ILLNESS. Determine history:

- Inquire about prior HIV testing and recent illnesses. An individual diagnosed within 6 months of HIV infection may benefit from early intervention regardless of labs.
  - Evidence such as a negative HIV test prior to the positive test, a history of a flu-like illness prior to HIV diagnosis, or a history of recent high risk activities may help determine time of infection.
  - If it is determined that the infection was recently acquired, consultation with an HIV expert provider is recommended.
  - Unfortunately, most patients are not diagnosed with HIV until chronic infection is established, but it is worth making this determination as soon as possible.
- If the initial visit is with a patient with a history of HIV, obtain date of diagnosis and any treatment history.
  - For antiretroviral medications, include all regimens, dates of use, and reasons for discontinuation. Since many patients recognize their meds only by color or size, it helps to have a picture chart of HIV medications to assure accurate identification.
  - Include a history of lab values (lowest CD4 count) and most recent labs, if available.
  - Find out where previous care was provided and ask if records can be obtained from that provider.

PREVIOUS MEDICAL HISTORY. Ask about significant previous medical history including:

- Transfusions
- Opportunistic diseases
- Hospitalizations
- Mental health or substance use treatment history

MEDICATIONS. Discuss use of all current medications:

- HIV treatment
- Medications to prevent opportunistic infections
- Medications prescribed for conditions other than HIV
- OTC medications
- Herbal remedies

ALLERGIES. Record allergic reactions; inquire about previous antibiotic use

IMMUNIZATIONS. History of vaccinations, childhood and adult

REVIEW OF SYSTEMS. Ask about:

- Weight loss/gain
- Fever
- Night sweats
- Dysuria
- Nausea/vomiting
- Loss of appetite
- Fatigue
- Diarrhea
- Genital/anorectal lesions, discharge and/or tenderness
- For women, include last menstrual period, menstrual irregularities, and pregnancy history

HEALTH MAINTENANCE. Ask about:

- Previous primary, dental, and eye care
- Last Pap smear (cervical and/or anal), history of abnormal Pap smears
- History of PPD and/or chest X-ray

SOCIAL. Start with less threatening areas to establish communications and build rapport:

- Employment (financial resources)
- Housing (stability, safety of neighborhood)
- Living arrangements (who patient lives with)
- Responsibilities (children, other relatives, partners, pets, property)
- Travel, especially to areas with endemic infectious diseases
- Alcohol and tobacco use
- Other substance use – "Do you now or have you ever used drugs that weren't prescribed by a physician? How do/did you use them (i.e. inject, smoke, snort, etc.)? Do/did you share your equipment with others?"
- Sexual activity – "Are you sexually active? Do you have sex with men, women, or both? How do you protect yourself and your partners from sexually transmitted diseases?"
- Inquire about history of violence, including forced sex and domestic abuse
- Ask about support – "Who have you told about your diagnosis? How are they helping you with your diagnosis?"

PHYSICAL ASSESSMENT

PHYSICAL EXAM. Focus on the following during comprehensive physical exam:

- Skin: Note any rashes or lesions
- HEENT: Perform thorough oral, eye, and ear exams
- Lymph: Determine extent of lymph node enlargement, if any
- Heart: Assess rate and note presence of murmurs or extra beats
- Lungs: Assess breath sounds throughout lung fields
- Abdomen: Measure liver span, note splenomegaly
- Neurologic: Test reflexes and sensations in lower extremities, assess mental status

NOTE: depending on time, prioritization of needs, and patient comfort, GU and rectal exams may be deferred, but should be mentioned in the plan to complete the physical exam.

- Genitourary: Check for discharge, lesions, or tenderness
- Anal/ Rectal: Check for discharge, lesions, or tenderness; a history of anal receptive sexual intercourse should initiate complete rectal exam including anoscopy

LABS. Complete labs to establish current problems/disease state:

- HIV antibody (ELISA & Western blot) as needed
- HIV RNA Quantitative (viral load)
- CD4 profile
- CBC with differential
- Basic metabolic panel including liver function tests
- Baseline random glucose & cholesterol
- Hepatitis profile (anti-HAV [IgG], anti-HBV, HBsAg, HbcAb, & anti-HCV)
- STD testing, if appropriate, including gonorrhea, chlamydia, and syphilis (RPR or VDRL)
- Consider resistance testing (genotyping/phenotyping) especially with recently-infected patients

ASSESSMENT. Determine HIV stage (asymptomatic, symptomatic, or AIDS); include other diagnoses

PLAN

ADDRESS DIAGNOSES AND PLANS FOR CARE. Provide comprehensive health care using referrals and consultations as required.

HEALTH MAINTENANCE. Considerations include:

- Vaccinations, including pneumovax
- PPD placement
- Pap smear and breast exam
- Anal cytology, if appropriate
- Age appropriate health and wellness exams and follow-up

EDUCATION. Discuss:

- HIV pathophysiology including significance of viral load & CD4 count
- Routine lab tests with expected monitoring intervals
- Plan of care including need for immunizations and routine health maintenance
- The importance of adherence to antiretroviral regimens
- HIV transmission and methods to decrease risks to partners
- Follow-up – when to return, how to contact providers between appointments if needed

RESOURCES

AIDSinfo
www.aidsinfo.nih.gov
A service of U.S. Department of Health and Human Services providing information on HIV/AIDS clinical trials and treatment.
1-800-HIV-0440 (1-800-448-0440)

AIDS InfoNet
www.aidsinfonet.org
Provides fact sheets on treatments, prevention, social services, and web resources. Easy to print, appropriate for patient and clinician education; updated on a regular basis. Available in English and Spanish.

HIV Telephone Consultation Service for Health Care Providers
www.ucsf.edu/hivcntr
A national HIV telephone consultation service for health care providers offering up-to-date clinical information and individualized consultations from clinicians experienced in HIV care. **1-800-933-3413**

Mountain Plains AIDS Education and Training Center
4200 East Ninth Avenue, Box A089 • Denver, Colorado 80262
Phone: 303-315-2516 • FAX:303-315-2514
www.uchsc.edu/mpaetc

HIV Adult/Adolescent Health Maintenance

Patient Name: ____________________ **Date:** __________ **Chart #:** __________

		Recommendation	Date	Date	Date	Date	Date
Periodic Screening	health history update	q 3 mo					
	complete physical exam	annual					
	interval physical exam	q 3 mo					
	breast exam/testicular exam	with physical					
	dental exam	q 6 mo					
	hearing/vision exam	annual					
	retinal exam	annual/q 6 mo CD4<100					
	Pap/pelvic exam	annual/q 6 mo CD4<200					
	anal Pap	annual if anal intercourse					
	digital rectal exam	annual 40 y/o or earlier					
	stool guaiac	annual over 50 y/o					
	EKG	if applicable					
	BE/sigmoidoscopy	over 50 y/o, q 3-5 years					
	mammogram	annual over 40 y/o					
	PPD/CXR	annual					
	cholesterol/triglycerides	q 6 mo					
	liver function tests	q 6 mo					
	HIV panel (CBC, CD4,VL)	q 3 mo					
	hepatitis screen	initial & PRN					
	RPR/STD screen	Initial, annual, & PRN					
Immunizations	tetanus/diphtheria	q 10 yrs after 1° series					
	pneumococcal	q 6 years					
	influenza	annual					
	MMR	under 40, no hx of disease					
	hepatitis B	if no hx of disease					
	hepatitis A	if applicable					
	varicella	CD4>500, no hx of disease					
Risk Assessment	tobacco	annual					
	alcohol	annual					
	drugs	annual					
	mental health: stress, anxiety, depression, suicide ideation	annual					
	diet/exercise	annual					
	HIV/STD prevention	annual					
	geriatric functional status	annual over 60 y/o/PRN					
	seat belt/helmet use	annual					
	pregnancy/contraception	annual					
	advanced directives	annual					
	emotional support	annual					
	domestic violence/abuse	annual					
	hepatitis A, B, C	annual					

HIV LAB & MEDICATON FLOW SHEET

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Patient Name: ________________ **Provider:** ________________ **Chart #:** ________

Log	# virus	Patient Viral Load									Comments
6.0	1,000,000										
	750,000										
	500,000										
	250,000										
5.0	100,000										
	75,000										
	50,000										
	25,000										
4.0	10,000										
	7,500										
	5,000										
	2,500										
3.0	1,000										
	750										
	500										
	250										
2.0	100										
	75										
	50										
	25										
1.0	10										
	7.5										
	5										
	2.5										
	0										
CD4+ cell count											
Date											
Medications:											