REPUBLIC OF ZIMBABWE

MINISTRY OF HEALTH AND CHILD CARE

VOLUNTARY MEDICAL MALE CIRCUMCISION:

CLIENT INTAKE FORM

PROVINCE: ..... **PROVINCE CODE:** .....

DISTRICT: ..... **DISTRICT CODE:** .....

FACILITY NAME: ..... **FACILITY CODE:** .....

PERIOD: **FROM** ..... **TO** .....

Revised April 2014

male circumcision

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VOLUNTARY MEDICAL MALE CIRCUMCISION CLIENT INTAKE FORM

VMMC Client Number (*year-M-5 digit number):*_____ Date of Visit: _____ Facility: _____ Facility Code: _____ District: _____ Province: _____

PERSONAL DETAILS

Client's Name:

National ID: _____

D.O.B: _____ Age: _____ years _____ months
dd/mm/yyyy

Client's Physical Address (Residence/Village):

Client Tel: Home: _____
Mobile: _____
Work: _____

Alternate Address: ☐ Work ☐ School ☐ Friend/next of kin

Address: _____

Alternate Tel: _____

Name of friend/next of kin: _____

FACILITY

Type of Site/Service (tick appropriate):

☐ Static site ☐ Outreach/Mobile site: Name/location: _____

How did client learn about the service? (Tick all that apply)

☐ Friend/family
☐ Partner/Spouse
☐ Health worker
☐ Poster
☐ Newspaper
☐ Other (Specify) _____
☐ Other client
☐ Community mobiliser
☐ Television(TV)
☐ Radio
☐ Leaflet

Referred from: (Tick all that apply)

☐ New Start Centre
☐ Community mobiliser
☐ Workplace
☐ Other (specify) _____
☐ School
☐ HTC program
☐ Health worker

INDIVIDUAL COUNSELING

Primary reason for circumcision: (Tick all that apply)

☐ Partial HIV protection
☐ Sexual pleasure
☐ STI protection
☐ Medical
☐ Other (specify) _____
☐ Appearance
☐ Hygiene
☐ Cultural/social
☐ Religious

Has client been tested for HIV before?	☐Yes	☐No	
If Yes, when? -Recently, less than one month ago	☐Yes	☐No	
-Between 1 month and 3 months ago	☐Yes	☐No	
-More than 3 months ago	☐Yes	☐No	
-Other, indicate			
If tested before, What was the result:	Neg	Pos	Unk
If tested before, provide Referral Form / Proof of test	☐Yes	☐No	
HIV test done for VMMC:	☐Yes	☐No	
HIV test result	Neg	Pos	Unk
If HIV test positive: WHO clinical stage:			
If HIV test positive: CD4 cell count, if known:			

MEDICAL SCREENING/PHYSICAL EXAMINATION

Vital signs: Weight (kg)_____ Temperature_____ ^{0}C

Blood Pressure_____/_____ mmHg Pulse _____b/min

Any known allergies? ☐ Yes ☐ No

If yes, specify: _____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, specify: _____

Have you ever had an operation? ☐ Yes ☐ No

If yes, specify: _____

Have you ever been diagnosed with any of the following?

Anaemia	☐Yes ☐No	Peripheral vascular disease	☐Yes ☐No
Cancer	☐Yes ☐No	Heart condition	☐Yes ☐No
Hypertension	☐Yes ☐No	Liver disease	☐Yes ☐No
Bleeding disorder	☐Yes ☐No	Kidney disease	☐Yes ☐No
Diabetes mellitus	☐Yes ☐No	Thyroid disease	☐Yes ☐No

Other (specify): _____

Family history of abnormal bleeding/known clotting disorder? ☐Yes ☐No

General condition:

Ill looking	☐Yes ☐No	Lymphadenopathy	☐Yes ☐No	Jaundice	☐Yes ☐No
Healthy	☐Yes ☐No	Wasting	☐Yes ☐No	Pallor	☐Yes ☐No
		Dehydration	☐Yes ☐No	Other (specify):	_____

Do you have any of the following complaints?

Painful/weak erection	☐Yes ☐No	Pain on urination	☐Yes ☐No	Difficulty in retracting the foreskin	☐Yes ☐No
Swelling of the scrotum	☐Yes ☐No	Urethral discharge	☐Yes ☐No	Other (specify):	_____
		Genital sore	☐Yes ☐No		_____

Genital Exam: Any of the following?

Hypospadias	☐Yes ☐No	Torsion of the penis	☐Yes ☐No	Posthitis	☐Yes ☐No
Genital Ulcers	☐Yes ☐No	Preputial Adhesions	☐Yes ☐No	Urethral discharge	☐Yes ☐No
Genital warts	☐Yes ☐No	Phimosis	☐Yes ☐No	Others (describe):	_____
Balanitis	☐Yes ☐No	Paraphimosis	☐Yes ☐No		_____
		Epispadias	☐Yes ☐No		_____

CIRCUMCISION METHOD ELIGIBILITY

For adults ages 18 and over:

Informed Consent Granted ☐ Yes ☐ No , clinician's initials: _____

For minors under age 18:

Parental/guardian signature : ☐ Yes ☐ No , clinician's initials: _____

How was verification of consent with parent/guardian obtained?

☐ Telephone ☐Visit ☐ Mail ☐ Other (specify) _____

Client is eligible for which circumcision method (Tick all applicable)

☐ Surgical circumcision ☐ PrePex circumcision ☐ Other (specify) _____

Of the appropriate methods, the circumcision method chosen by client

☐ Surgical circumcision ☐ PrePex circumcision ☐ Other (specify) _____

CIRCUMCISION PROCEDURE:

Date of Procedure/Device Placement: _____

Circumciser's Name: _____ ☐ Doctor ☐ Nurse ☐ Other (specify) _____

Assistant's Name: _____ ☐ Doctor ☐ Nurse ☐ Other (specify) _____

For Surgical Male Circumcision:

Procedure Type:
☐ Forceps-guided ☐Other (specify) _____

Anaesthesia:
Local anaesthetic: (**circle type and fill in dose**)
1% lignocaine _____ mls
2% lignocaine _____ mls
0.5% Bupivacaine _____ mls

Diathermy used ☐ Yes ☐ No
If yes; Settings _____
Procedure start time: _____ Procedure end time: _____

For PrePex Male Circumcision:

Device Size _____
Device Batch ID #: _____
Device Expiry Date: _____ Time _____
Topical anaesthesia: ☐ Yes ☐ No
If Yes, Specify: _____

Clinical Notes:

Adverse Events (AEs) During Procedure

☐ Client had **NO** adverse event(s) diagnosed during MC procedure/placement visit (skip to post-procedure assessment)
☐ Client had adverse event(s) diagnosed during MC procedure/placement visit (prior to discharge):

	Mild	Moderate	Severe
Pain (A-PA)	☐	☐	☐
Bleeding (A-BL)	☐	☐	☐
Anaesthetic-related problem (A-AN)	☐	☐	☐
Damage to penis (A-SD)	☐	☐	☐
Excess skin removal (A-SD)	☐	☐	☐
Difficulty with placement (A-DP)	☐	☐	☐
Device malfunction (A-DM)	☐	☐	☐

If any AEs occurred, describe AE management: _____

Post-Procedural Assessment (before discharge)

Vital signs:
Blood Pressure_____/_____ mmHg

Pulse _____b/min

Dressing or PrePex device appropriately placed:
☐ Yes ☐ No

Client provided post-procedure written instructions:
☐ Yes ☐ No

Client given MC Client Card and instructed to return for next follow-up visit:
☐ Yes ☐No

Analgesia given:

☐ Yes, Drug: _____ ☐No

General condition: _____

Date of next scheduled visit: _____

Discharged by: _____

Signature: _____

Day 2: Post-circumcision visit(Surgical)

Date: _____
Visit interval: ☐ Before (Bf) ☐ On time (OT) ☐ Late (Late)

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes: AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Comments/Management:

Day 7: Device removal

Date: _____
Visit interval: ☐ Before (Bf) ☐ On time (OT) ☐ Late (Late)

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes: AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Day 7: Post-circumcision visit

Date: _____
Visit interval: ☐ Before (Bf) ☐ On time (OT) ☐ Late (Late)

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes: AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Comments/Management:

Day 14: Post-device placement visit

Date: _____
Visit interval: ☐ Before (Bf) ☐ On time (OT) ☐ Late (Late)

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Comments/Management:

Additional review: If applicable

Date: _____

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes: AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Comments/Management:

Additional review: If applicable

Date: _____

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Day 42: Post-circumcision visit

Date: _____
Visit interval: ☐ Before (Bf) ☐ On time (OT) ☐ Late (Late)

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes: AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Wound healing complete? ☐ Yes ☐ No

If No, additional visit date:

Resumed sexual activity ☐ Yes ☐ No

If yes, number of weeks _____ weeks

Counseled to reduce sexual risk ☐ Yes ☐ No

If yes; **Risk reduction plan** (Tick all applicable):

☐None ☐Dual Protection ☐Use condoms ☐Other (specify) _____
☐Decrease number of sex partners ☐Abstinence ☐Monogamy

Day 49: Post-device placement visit

Date: _____
Visit interval: ☐ Before (Bf) ☐ On time (OT) ☐ Late (Late)

Name of nurse/doctor:

Any Adverse Event at this visit? ☐Yes ☐No

If Yes AE code _____ Severity: ☐ Mild ☐ Moderate ☐ Severe

Wound healing complete? ☐ Yes ☐ No

If No, additional visit date:

Resumed sexual activity ☐ Yes ☐ No

If yes, number of weeks _____ weeks

Counseled to reduce sexual risk ☐ Yes ☐ No

If yes; **Risk reduction plan** (Tick all applicable):

☐None ☐Dual Protection ☐Use condoms ☐Other (specify) _____
☐Decrease number of sex partners ☐Abstinence ☐Monogamy

Additional clinical management of Adverse Events or additional comments/notes: