Male Circumcision Record Form

SECTION A: Client Demographics

Have you ever been to another other SU Site? ☐ Yes ☐ No

If yes, write previous site code

First Name

Surname

National ID No.

Unique ID No.for woman

Client UID

Chart NO.

Age:

DOB: D D / M M / Y Y Y Y

Address

Mobile No.

Region/ Country

Site Code

First visit date: D D / M M / Y Y Y Y

Site for follow up care

SECTION B: Socio-Medical History

B1. Relationship

- ☐ Married - 1 wife
- ☐ Single - regular partner
- ☐ Married - polygamous
- ☐ Divorced/Separated
- ☐ Single - no regular partner
- ☐ Other (specify below)

Other:

B2. How did you learn of this service?

- ☐ Friend/Family
- ☐ Poster/Newspaper/Leaflet
- ☐ Partner/Spouse
- ☐ Community mobilizer
- ☐ Other Client
- ☐ TV/Radio
- ☐ Health worker

B3. Primary reason for circumcision:

- ☐ Partial HIV protection
- ☐ Sexual pleasure
- ☐ STI protection
- ☐ Appearance
- ☐ Social/Religious
- ☐ Hygiene
- ☐ Medical (specify below)
- ☐ Other (specify below)

Medical:

Other:

B4. Have you been treated for an STI in the last 3 months?

☐ Yes ☐ No

B5. Do you have any of the following conditions (read aloud each)?			**If yes, are you currently taking treatment?**	
Haemophilia or bleeding disorders	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	☐ Yes	☐ No

B6. Do you have any of the following complaints?

Urethral discharge	☐ Yes	☐ No
Genital sore/ulcer	☐ Yes	☐ No
Pain on erection	☐ Yes	☐ No
Swelling of the scrotum	☐ Yes	☐ No
Pain on urination	☐ Yes	☐ No
Difficulty retracting foreskin	☐ Yes	☐ No

Others:

B7. Have you ever had a surgical operation?

☐ Yes ☐ No

If yes, please specify below

Type of surgery	Date of surgery
	D D / M M / Y Y Y Y
	D D / M M / Y Y Y Y
	D D / M M / Y Y Y Y
	D D / M M / Y Y Y Y

SECTION C: HIV Test in the past 3 months

C1. HIV test status in the past 3 months

HIV test results:

☐ R ☐ NR ☐ IND ☐ UK/SR/RF

If HIV test performed elsewhere, results must be documented in writing and verifiable (recorded by name)

HIV Test Date: D D / M M / Y Y Y Y

Test Location Code

Other Site

Code No.For MC Counselor:

MC Counselor's Signature:

SECTION D: Physical Examination and Triage

D1. Physical examination

Phymosis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Paraphymosis	☐ Yes	☐ No	Balanitis	☐ Yes	☐ No
Epispadias	☐ Yes	☐ No	Torsion	☐ Yes	☐ No
Hypospadias	☐ Yes	☐ No	Foreskin attached to glans	☐ Yes	☐ No

Date of Service for STI D D / M M / Y Y Y Y

Others:

SECTION D: Physical Examination and Triage Continued

D2. Vital Signs:

Blood Pressure ___ / ___ Weight (kg) ___

Pulse ___

Pallor ☐ Yes ☐ No Lymphadenopathy ☐ Yes ☐ No

Wasting ☐ Yes ☐ No

Nurse's Name ___

Nurse's Signature

D3. Allergies: ___

D4. Current medications:

On ART ☐ Yes ☐ No

ART Regimen ___

Other ___

SECTION E: Surgery and Intra Operative Notes

MC Date D D / M M / Y Y Y Y

Start Time ___ : ___

Anaesthesia
Macaine, 0.5% ___ ml
Lignocaine, 1% ___ ml
Lignocaine, 2% ___ ml

DPNB ☐ DPNB + ring block ☐

Method: ☐ Sleeve ☐ Dorsal Slit ☐ Forceps Guided

Suture: ☐ Chromic ☐ Plain gut ☐ Vicryl rapide

Diathermy used: ☐ Yes ☐ No

MC Surgeon ___

Assistant 1 ___

Assistant 2 ___

End Time ___ : ___

Surgeon's Signature: ___

Blood Pressure ___ / ___ Pulse ___

Complications/Intra-op AEs
☐ Yes ☐ No

If yes specify below

Intra-op AE

AE (Code) mark all that apply	Mild (1)	Mod (2)	Sev (3)
☐ Anaesthesia reaction (AN)	☐	☐	☐
☐ Bleeding (BL)	☐	☐	☐
☐ Damage to Penis (DP)	☐	☐	☐
☐ Excess Skin Removal (ES)	☐	☐	☐
☐ Insufficient Skin (IS)	☐	☐	☐
☐ Occupational Exposure (OT)	☐	☐	☐
☐ Pain (PA)	☐	☐	☐

Disposition:

☐ Hold in recovery & monitor for 20 min; discharge home with standard instructions; FU within 2 days

☐ Hold in recovery & monitor for ___ min; discharge home with standard instructions; FU within ___ days

☐ Other (specify)

Discharge Nurse's Name ___

Discharge Nurse's Signature ___

SECTION F : Post Operative Review Visits

F1. Visit 1

Reviewed by: ___

Visit Date: D D / M M / Y Y Y Y

AE Present: ☐ Yes ☐ No

AE (Code)	Severity (Code)	Diagnosis date at this severity
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y

Signature: ___

F2. Visit 2

Reviewed by: ___

Visit Date: D D / M M / Y Y Y Y

AE Present: ☐ Yes ☐ No

AE (Code)	Severity (Code)	Diagnosis date at this severity
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y

Signature: ___

F3. Visit 3

Reviewed by: ___

Visit Date: D D / M M / Y Y Y Y

AE Present: ☐ Yes ☐ No

AE (Code)	Severity (Code)	Diagnosis date at this severity
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y

Signature: ___

Post Operative Adverse Event Codes

BL	Exessive bleeding	TO	Torsion of penis, new onset
DP	Damage to penis	PA	Pain
ED	Sexual or erectile Dysfunction	SD	Scarring/Disfigurement
ES	Exessive skin removal	SH	Swelling of the penis/scrotum, hematoma
IN	Infection	VO	Voiding problems
IS	Insufficient skin	WD	Wound disruption/Dehiscence

Fill out each follow-up visit section completely. Add detailed clinical notes on inside cover of client medical record folder as necessary.

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