MOUNTAIN COUNTIES CASE MANAGEMENT PROGRAMS

INITIAL TREATMENT ADHERENCE EVALUATION

Client Name: _____ Program/File#: _____

(If client is a minor these questions will be addressed with the parent or legal guardian responsible for the care of the child)

Parent or Legal Guardian: _____

How sure are you (the client) that:	**Not sure at all**	**Somewhat sure**	**Very sure**	**Extremely sure**
1. The medication will have a positive effect on your health?	☐	☐	☐	☐
2. If the medication is not taken exactly as instructed, the HIV in your body will become resistant to HIV medications?	☐	☐	☐	☐

Social Support:	**Very dissatisfied**	**Somewhat dissatisfied**	**Somewhat satisfied**	**Very satisfied**
1. In general, how satisfied are you with the support you get from your friends & family members?	☐	☐	☐	☐
	Not at all	**A little**	**Somewhat**	**A lot**
2. To what extent do your friends or family members help you remember to take your medication?	☐	☐	☐	☐

Most anti-HIV medications need to be taken on a schedule, such as "2 x's a day" or "3 x's a day" or "every 8 hours." How closely do you follow your specific schedule?

Never ☐ Some of the time ☐ About half the time ☐ Most of the time ☐ All of the time ☐

Do any of your anti-HIV medications have special instructions such as "take with food" or "on an empty stomach" or "with plenty of fluids?"

Yes ☐ No ☐

If yes, how often did you follow those special instructions?

Never ☐ Some of the time ☐ About half the time ☐ Most of the time ☐ All of the time ☐

When was the last time you missed or skipped taking any of your medications?

Within the past week ☐ 1-2 weeks ago ☐ 2-4 weeks ago ☐

1-3 months ago ☐ More than 3 months ago ☐ Never miss or skip medications ☐

People miss or skip taking their medications for various reasons. The following questions are to identify why you may have missed or skipped taking ANY of your medication.

How often have you missed or skipped taking any medication because you:	Never	Rarely	Sometimes	Often
1. Were away from home?	☐	☐	☐	☐
2. Were busy with other things?	☐	☐	☐	☐
3. Simply forgot?	☐	☐	☐	☐
4. Had too many pills to take?	☐	☐	☐	☐
5. Wanted to avoid side effects?	☐	☐	☐	☐
6. Did not want others to notice you taking medication?	☐	☐	☐	☐
7. Did not want to take medication at work?				
8. Had a change in daily routine?	☐	☐	☐	☐
9. Felt like the drug was toxic/harmful?	☐	☐	☐	☐
10. Fell asleep/slept through dose time?	☐	☐	☐	☐
11. Felt sick or ill?	☐	☐	☐	☐
12. Felt depressed/overwhelmed?	☐	☐	☐	☐
13. Had problems taking pills at specified times (with meals, on empty stomach, etc.)?	☐	☐	☐	☐
14. Ran out of pills?	☐	☐	☐	☐

People have various health habits that may have an effect on how they might miss taking their medication. The following questions ask about your alcohol and drug use, past and current.

1. **How often have you had a drink containing alcohol in the last 30 days?**
   Daily ☐ Nearly every day ☐ 3-4 x's a wk ☐ 1-2 x's a wk ☐ 2-3 x's a mo.☐ Once a mo.☐ Never ☐ If **never** skip ahead to question #3

2. **On days when you drank an alcoholic beverage in the last 30 days, how many drinks did you usually have all together?**
   1-2 drinks/day ☐ 3-4 drinks/day ☐ 5-6 drinks/day ☐ 9-11 drinks/day ☐
   12 or more drinks/day☐

3. **Have you ever used marijuana?**
   Yes ☐ No ☐
   If answered "yes" to the above question, have you used this drug within the past 6 months?
   Yes ☐ No ☐

4. **Have you ever used cocaine (powder, crack, or freebase)?**
   Yes ☐ No ☐
   If answered yes to the above question, have you used this drug within the past 6 months?
   Yes ☐ No ☐

5. **Have you ever used amphetamines (speed)?**
   Yes ☐ No ☐
   If answered "yes" to the above question, have you used this drug within the past 6 months?
   Yes ☐ No ☐

6. **Have you ever used heroin?**
   Yes ☐ No ☐
   If answered "yes" to the above question, have you used this drug within the past 6 months?
   Yes ☐ No ☐

7. **Are you currently in methadone treatment?**
   Yes ☐ No ☐
   If *No:* Have you ever been in methadone treatment?
   Yes ☐ No ☐

Nursing observations of possible barriers to medication adherence:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Nursing Interventions:

Is client in need of prescription refills at this time? ☐ No ☐ Yes, if *yes;*
Client to get prescriptions refilled ☐ Prescription refills called in to clients pharmacy by NCM ☐

Nursing recommendations for improved medication adherence:
Client adherent to current medication regimen ☐
Discuss and determine daily routines and best times for medication administration ☐
Provide written time schedule for administration of medications ☐
Referral to Treatment Advocate ☐ Date of scheduled app't with Tx Advocate:_____
Med Cassette ☐

- ☐ Client instructed in procedure with return demonstration
- ☐ Clients primary caregiver instructed in procedure with return demonstration
- ☐ **Other, *specify;*_____**

_____ _____
NCM Signature **Date**