**FORMULARIO DE PEDIATRÍA**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Institución:​ |  | | Medico solicitante:​ |  | | Tel. del médico:​ |  | |  |  | | |  |  | | --- | --- | | Email institucional:​ |  | | N​o ​de caja profesional:​ |  | |  |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***Cédula de Identidad*** | ***Año de***  ***nacimiento*** | ***Mes de***  ***nacimiento*** | ***Día de***  ***Nacimiento*** | **INICIALES** | | | | ***Sexo*** | | **Apellido**  **padre** | **Apellido**  **Madre** | **1er nombre** | **2º nombre** | |  |  |  |  |  |  |  |  |  |      |  | | --- | | Fecha de diagnóstico de la infección por VIH: | | ***Vía mas probable de adquisición del VIH(marque con una X)*** |        |  |  | | --- | --- | | Vertical: | Sexual: | | Transfusión: | Otra/Se desconoce​**:** |      |  |  |  |  | | --- | --- | --- | --- | | ***En caso de transmisión vertical:*** | | | | | ¿Recibió profilaxis de la transmisión?​ ​**SI​** ​**NO** | | Especifique: | | | ¿Se suspendió lactancia? ​**SI​** ​**NO** | | | | | Comentarios: | | | | | ***En caso de TV, datos de la madre***  **​**Fecha de diagnóstico de la madre:​ **​** | | | | | ***Momento de diagnóstico de la madre*** | | | | | **Previo al embarazo:** | **Durante al embarazo:** | | ***En el parto o post-parto:*** |        |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | ***Del embarazo:*** | | | | | | | | | | PTMI | Plan de TARV en embarazo | AZT intra-parto | | | | Nevirapina peri-parto | | | |  |  | |  |  |  |  |  |  | |  |  | |  |  |  |  |  |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  | | | | |  |  | | | | |  |  | | | | |  | | | | | | ***Valores previos al inicio del primer TARV*** | | | | | | **Fecha** | | **CD4** | **Carga Viral** | **Comentarios** | |  | |  |  |  |        |  |  |  |  |  | | --- | --- | --- | --- | --- | | ***HISTORIA INMUNO-VIROLÓGICA y DE TARV*** | | | | | | **Fecha** | **CD4** | **Carga Viral (log)** | **TARV** | **Cambio por:** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |
| ***¿Recibe actualmente el TARV? ​SI: NO:*** |

|  |
| --- |
| ***¿Tiene el paciente test de resistencia previo? ​*SI NO** |

|  |
| --- |
|  |
|  |

|  |
| --- |
| ***Describa adherencia, necesidad de apoyo u otros aspectos que considere relevantes*** |

|  |  |
| --- | --- |
|  |  |

|  |
| --- |
| ***INFORMACIÓN SOLO REQUERIDA PARA PACIENTES SIN TARV*** |

|  |  |  |
| --- | --- | --- |
| El test de resistencia podrá realizarse en pacientes sin TARV:  1.RN con infección por TV  2.con una infección reciente (≤ 1 año),  3.en paciente con primoinfección sintomática reciente y, | | |
| 1.RN con infección por TV | Comentario: | |
| 2.Infección reciente: serología  previa de VIH negativa ≤ 1 año | Fecha:  (mes/año) | Comentario: |
| 3.Primoinfección sintomática | Fecha del cuadro clínico:  (mes/año) | Descripción: |
| 4.Otra situación | Describa: | |

|  |
| --- |
| ***Opinión de la Comisión ​Fecha:*** |

|  |  |  |
| --- | --- | --- |
| Se accede a la realización del test | Se posterga | No se accede |
| Comentarios: | | |
| **CONDICIONES DE ENVIO DE MUESTRA PARA ESTUDIO DE RESISTENCIA AL DEPARTAMENTO DE LABORATORIOS DE SALUD PUBLICA (DLSP)**  ●Extracción de sangre por punción periférica, recolectada en 3 tubos de 5 mL con anticoagulante EDTA.  ●Rotular los tubos con nombre o autogenerado, Cedula de Identidad y fecha de toma de muestra. Acondicionar para su transporte de acuerdo a las  normas de bioseguridad.  ●Una vez realizada la extracción mantener los tubos refrigerados a 4ºC (no congelar ni separar el plasma).  ●Dentro de la 12 horas de realizada la extracción deben llegar las muestras al DLSP, en las condiciones referidas ​acompañadas del formulario de  solicitud de Test de Resistencia aprobado por la Comisión de Resistencia a Antirretrovirales.  ●Departamento  de Laboratorios de Salud Pública (DLSP): Alfredo Navarro 3051 entrada  norte; Horario de recepción : Lunes a Jueves de 9 a 15hs. | | |

**Firmas:**

|  |
| --- |
| ***Interpretación del test de resistencia ​Fecha:*** |

|  |  |
| --- | --- |
| CI paciente​: | Institución​: |
| Médico solicitante​: | |
| *La/s*  *propuesta/s de TARV a continuación, surgen de la interpretación del*  *estudio de resistencia genotípica en base a la utilización combinada de*  *varios*  *algoritmos*  *de interpretación. Se propone el plan con mejores posibilidades de*  *éxito terapéutico y uno alternativo cuando es posible. El test de*  *resistencia*  *genotípica*  *tiene limitaciones y debe ser considerado como una herramienta más a*  *utilizar para lograr los mejores objetivos terapéuticos.* | |

|  |  |
| --- | --- |
| PLAN SUGERIDO 1 |  |
| PLAN SUGERIDO 2 |  |
| *Comentarios:* | |

**Firmas:**