health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Service Provider _____
Facility of service _____
Data month verified _____

Monthly District VMMC Verification Checklist

Check the following items	YES	NO	COMMENTS
Client Intake Form			
1. Client intake form available and filled in completely for each client			
2. Client name and surname, date of visit written legibly on the MMC client intake form			
3. Post-Operative review recorded (**day 2** and **day 7**) on all circumcised clients in the MMC client intake form			
Client Information in the MMC Register			
1. NDOH MMC Register Version 2 is being used			
2. MMC Register cover page is filled in correctly			
3. The date, month, and year of MMC is written on each page in the MMC Register			
4. Client's name and surname, BOB /ID no. and age written on each page in the MMC register			
5. HIV testing results, method of MMC, follow up visit (**day 2** and **day 7**) ticked on each page in the MMC register			
6. If any Adverse Events (AEs) recorded in the MMC register:			
a. Entered in the MMC AE Register			
b. Type and severity stated			
c. Referred			
d. Reported to district office within 24 hours (by phone)			
7. Name, signature and date by Data Clerk (capturing personnel) on each page in the MMC Register			
8. Name, signature and date by Facility Manager on each page in the MMC Register			
Client/guardian consent			
1. Valid consent available for each client and signed correctly with ID numbers/DOB			
2. For ages 10-17 years, a Birth Certificate/ID copy provided, if not, a sworn affidavit			
3. For ages 18 years and above, an ID copy is provided, if not, sworn affidavit			
4. Consenting parent/Guardian ID copy is provided, if not, sworn affidavit			
	MMC Register	**Clinical files**	**Nerve data /WEBDHIS**
Total recorded			

Compiled by _____
Date _____